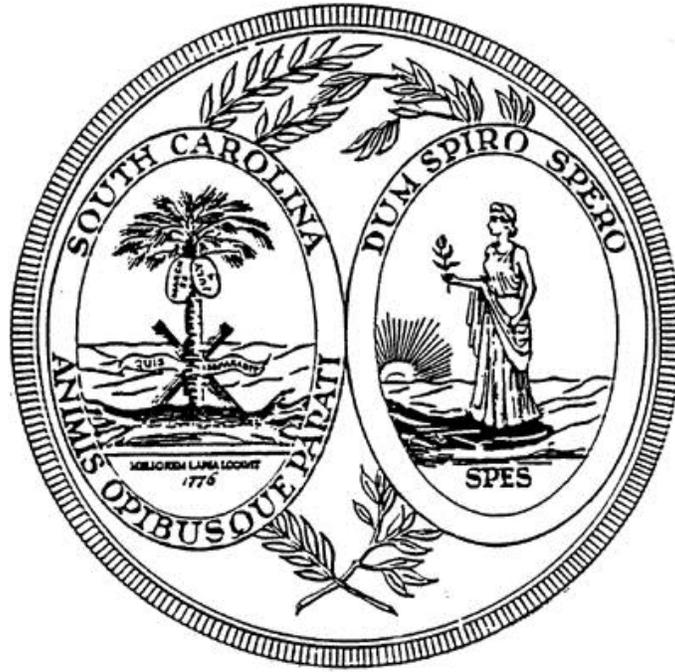


**State of South Carolina
Department of Health and Human Services**



EXECUTIVE ORDER 2013-02

**Final Report
May 15, 2013**

South Carolina Department of Health and Human Services

**EXECUTIVE ORDER 2013-02
FINAL REPORT**

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1.0 EXECUTIVE SUMMARY

A. APPROACH

Following the release of Executive Order 2013-02, the South Carolina Department of Health and Human Services (SCDHHS) formed a regulatory burden task force. The task force is composed of team members representing various business areas and needs across the Department. The task force met regularly since the end of February, and developed and implemented a plan to solicit written and oral comments from internal team members as well as the public.

The task force selected public forums and an internal staff survey as the key methods to collect comments as well as accepting written and oral comments via the telephone, electronic mail and U.S. Postal Service (USPS) mail.

In a review of policies, procedures, regulations and statutes, the task force developed a web-based repository via Microsoft SharePoint to collect all relevant documents. Tracking sheets were used to identify any changes needed.

The SharePoint repository also housed all comments, including internal and external, and the task force regularly reviewed the listing. All comments were categorized and assigned to the appropriate individual(s) for review and response preparation.

Following the close of the comment period, the task force developed the report that follows which identifies burdens, recommendations and other appropriate next steps.

B. PUBLIC FORUMS

SCDHHS planned three public forums across the state in early April to solicit oral comments from the public. A press release announcing the public forums and other means to submit burdens was distributed to media outlets across the state on March 19, 2013. Follow-up press releases were distributed to targeted media markets where forums were held: Charleston (distributed April 5), Spartanburg (distributed April 8) and Florence (distributed April 9). Articles on the public forums ran in the “Charleston Post & Courier,” “Florence Morning News” and several online media websites. Though the attendance was lower than expected at each forum, the quality of feedback from the public was very high. The table summarizes the attendance and number of comments received.

Location & Date	Attendees	Comments Received
North Charleston 4/9/13	11	15
Spartanburg 4/10/13	9	16
Florence 4/11/13	7	20

As attendees shared their comments, SCDHHS team members documented the burdens and recommendations on flip chart paper as well as electronically. Attendees were also encouraged to submit comments via comment cards and/or electronic mail, if applicable.

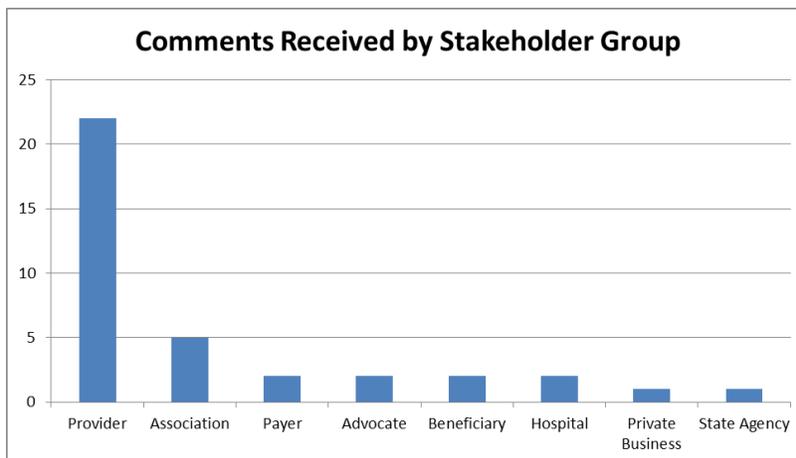
C. PUBLIC COMMENTS

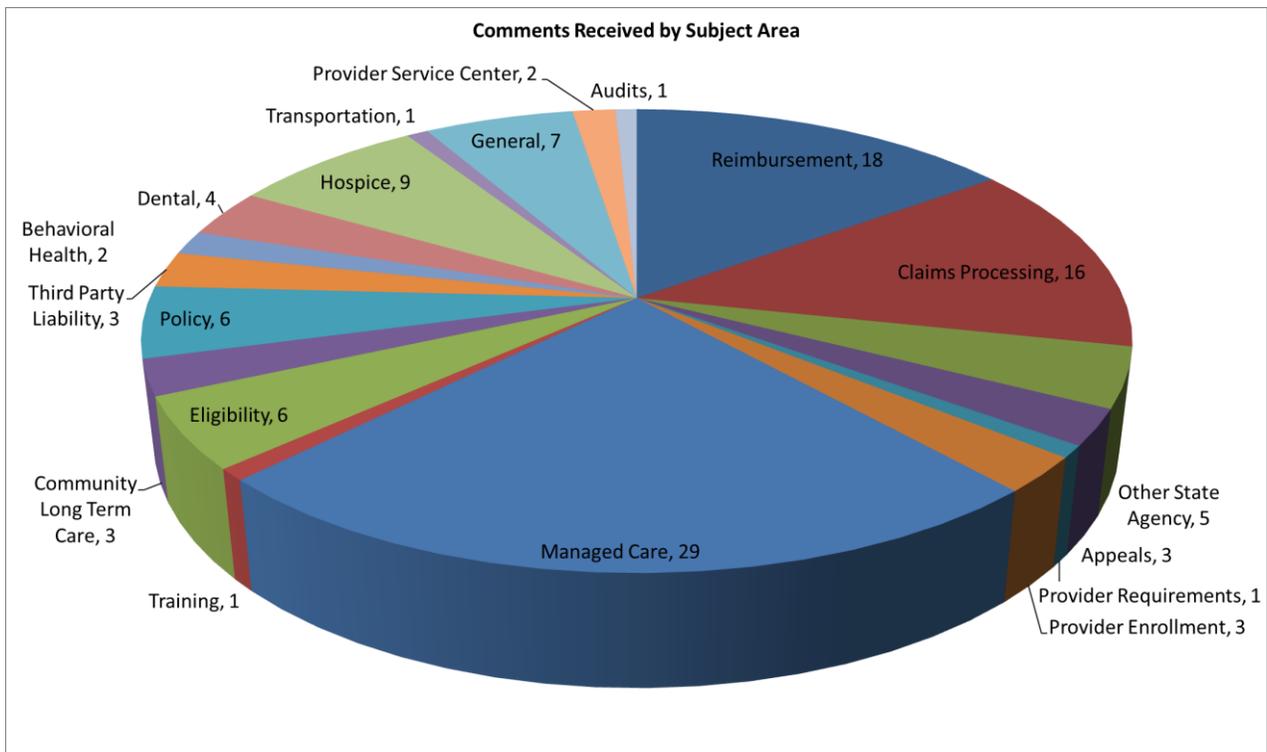
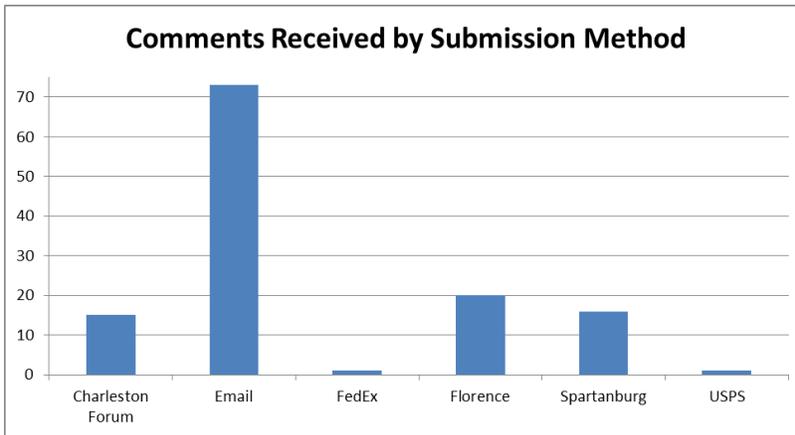
In addition to the public forums held, SCDHHS advertised the solicitation for public comments via provider bulletins, the Department’s website stakeholder listservs, the Medical Care Advisory Care (MCAC) meetings, and social media. The public was encouraged to submit comments by calling the Office of Communications or submitting comments via electronic or USPS mail.

Over the course of the collection period, SCDHHS sent out seven tweets through its Twitter account. These messages also appeared on the SCDHHS Facebook page. The table that follows is a complete listing on the messages.

Date	Message
3/20/13	@SCMedicaid seeks public feedback by April 12 to identify regulations that cause needless burdens on SC businesses: http://t.co/hW1axVGXER
3/27/13	Is there a SCDHHS policy burdening your business? @scmedicaid wants to hear from you. Call, email or attend a forum: http://t.co/C1w2NbSisF
4/3/13	Is there a SCDHHS policy burdening your business? @scmedicaid wants to hear from you. Call, email or attend a forum: http://t.co/J51B5NJOcV
4/9/13	Today, @SCMedicaid hosts public forum in Charleston to identify regulations that cause burdens on SC businesses: http://t.co/TqExEDRSdp
4/10/13	Today, SCDHHS hosts a public forum in Spartanburg to gather feedback on regulations causing burdens on SC businesses: http://t.co/SIJhB5ESiX
4/10/13	Residents in Florence have an opportunity to share input on policies burdening SC businesses at public forum tomorrow http://t.co/19ChCZK9F9
4/11/13	SCDHHS seeks input on policies burdening SC businesses. Can't make today's forum in Florence? You can call or email: http://t.co/5Tv8tGRB1J

The following tables and chart break down the 120 comments received by stakeholder type, submission method and subject area.

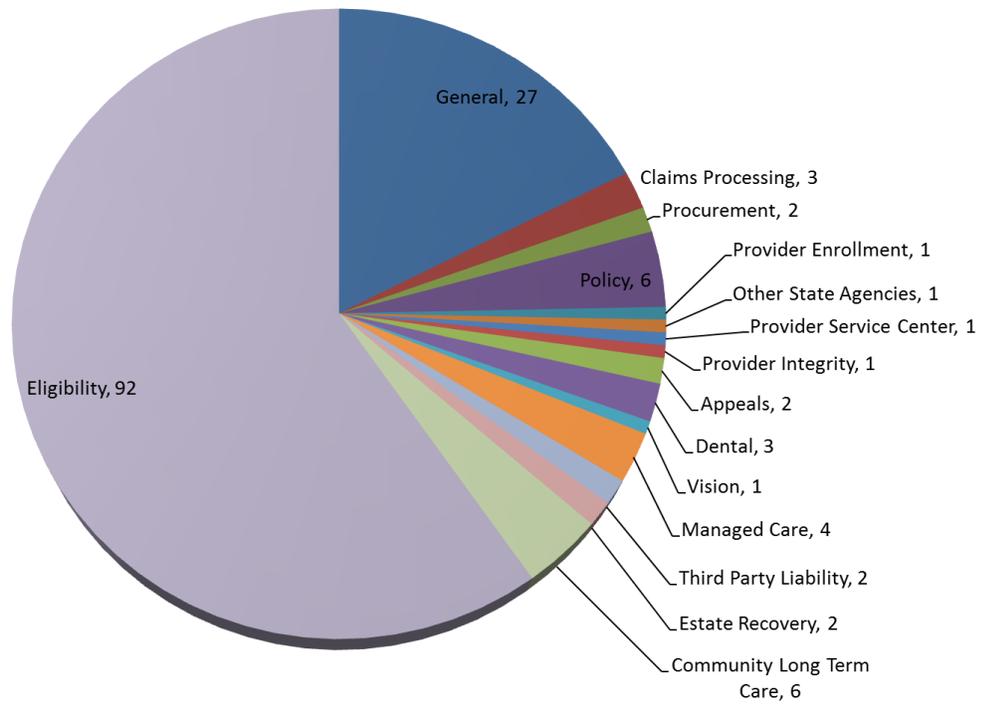




D. INTERNAL COMMENTS

The task force developed an internal survey that was distributed to all internal employees. Department-wide emails were distributed to solicit feedback from staff on March 2, March 15 and April 9. To provide context, Executive Order 2013-02 was referenced in the message, and employees were encouraged to identify any burdens observed in the field. Updates and reminders were also communicated at weekly management meetings from March 5 through April 9. 385 employees completed the survey, and a subset of those who completed the survey identified regulatory burdens resulting in 154 comments. The table that follows is a breakdown of the completed surveys by subject area.

Internal Comments Received by Subject Area



2.0 FINDINGS

SCDHHS received a variety of comments from the public and from staff regarding regulatory or other burdens on providers. The full listing of comments received is located in the appendices, including identifying information for those who submitted comments, and corresponding answers or clarification from appropriate SCDHHS staff.

While the following summary is not exhaustive of all the comments received and addressed by SCDHHS, the comments could be largely grouped into the following categories: process improvement/claim processing, prior authorization, communication/provider support, cost reports, managed care (MCOs), and conflicts with another state agency.

Process Improvement/Claims Processing

Comment: Several commenters pointed out process-related burdens that could be improved upon by the Department. Several commenters noted that Edit Correction Forms (ECF) require providers to expend man hours on manual work. Another commenter stated that often the ECFs are generated because system updates have not yet been loaded. Other commenters expressed frustration with the level of manual work of filing claims that require attachments, requirements for original paperwork that is then scanned in and destroyed by the Department, and lack of online submissions. Other commenters noted Medicaid forms for hospice should more closely mirror those used for Medicare in order to reduce burdens on providers who have to use entirely different forms.

Response: SCDHHS is aware of the frustrations surrounding the ECF process. The Department is currently working on a process to eliminate the ECFs by year end. SCDHHS is also reviewing many of the specific forms and processes identified by the commenters (i.e.: SCDHHS Medicaid Hospice forms and policies are under review at this time). Additionally, the Department is examining online submission of claims requiring documentation, and staff is examining hospice forms to better align them with Medicare. The Department will continue to work with stakeholders to seek input and address these concerns.

Comment: Several commenters expressed frustration with the Department's requirement that a form 945 be submitted to support a retroactive eligibility. Another suggested KePro, the Department's QIO that performs prior authorizations, be given access to the actual date of retro-enrollment approved for Medicaid recipients to prevent hospitals from having to provide documentation of the Department's process.

Response: The requirement to submit a form 945 regarding retroactive eligibility has been eliminated. Additionally, the Department is in the process of having the date of eligibility determination posted to the beneficiary's file. Staff members from SCDHHS and Clemson University, which supports the claims and eligibility systems, are working through the logistics of making this information available to providers.

Comment: Many providers expressed frustration with the Department's outdated billing and eligibility systems which lead to additional burdens placed on providers to turn over information that the Department should theoretically have.

Response: The Department recognizes the current burden placed on providers due to the age of its systems. However, a new Medicaid Management Information System (MMIS) and eligibility system are currently in the process of being implemented and should alleviate or relieve the concerns expressed.

Comment: Commenters noted the hassle associated with obtaining referrals for therapy services. A licensed independent practitioner (LIP) noted that it has to receive a referral from a physician or state agency in order to provide therapy services, per the Department's policy. The physician then has to send the LIPS referral form to KePro for an initial assessment authorization. Then KePro sends the LIP an approval letter if the referral is approved. After the LIP completes the assessment, the LIP must send the assessment to the physician who then completes the MNS and sends to KePro again for authorization for further services. The Department's policy of requiring the physician to complete a referral form often requires a second trip to a doctor for an unnecessary visit which is then paid by Medicaid. Requiring a referral and trip to the doctor also means parents are often unable or unwilling to take that extra step and children do not receive services they need.

Response: The Department is already examining this process to reduce the hassle factor and to comply with the Mental Health Parity Law.

Prior Authorization

Comment: Both internal and external individuals commented on the burden of the prior authorization process. Some commenters suggested investing more resources in performing post payment reviews and private training and/or progressive reviews with problem providers instead of requiring all providers to utilize prior authorization.

Response: Prior authorization eliminates payment for services that are not medically necessary. SCDHHS could potentially benefit from investing in personnel with the expertise to review medical necessity determinations on a retrospective basis. However, at this time, SCDHHS has chosen to monitor the medical necessity and appropriateness of payments upfront versus having a retrospective review process focused on recoupment of improper payments. Recoupment is often a lengthy, expensive, and litigious process which can often be avoided by utilizing prior authorizing services up front. However, SCDHHS will continue to consider burdens identified by providers in future actions regarding prior authorization and is in favor of creating a "trusted" provider process that would not require the submission of a PA if they met certain standards and that their performance would be monitored retrospectively through audit.

Comment: Some providers expressed difficulty comply with KePro's submission timelines and that, once information is submitted, KePro is sometimes slow to respond. Another commenter stated DentaQuest, the Department's dental administrative service organization, often takes up to the three weeks to authorize hospital dental visits. Providers stated this delay is burdensome

because often they must continue to provide services to a beneficiary while awaiting a response from the third party contracted to handle prior authorizations. Other commenters noted it is difficult to correspond with the contractors or receive a follow up or response.

Response: SCDHHS has contracted with these and other entities to perform its prior authorization services. KePro's submission deadlines are in line with the prior authorization requirements of other insurers in the state. However, the Department is aware that some providers who are new to the prior authorization process have had some initial difficulty with the process. This appears to be resolving itself as providers becomes more familiar with the process. The dental contract is up for renewal next year and all options are being reviewed in terms of options for staying with an ASO or moving to another model. SCDHHS will address the concerns raised about communications between providers and the contractors.

Comment: Concerns were expressed internally about the large number of appeals arising from KePro denials. Commenters stated it appeared KePro was directing all providers to appeal determinations instead of reaching out to providers to resolve denials, outstanding information, etc.

Response: SCDHHS has invested in professional organizations such as KePro to perform reviews for medical necessity. Medical necessity determinations can only be made when sufficient and necessary medical information has been submitted by the provider to justify the need. KePro processes the claims in accordance with the Department's policy and does not have authority to discuss administrative denials that take place because the provider fails to follow the Department's policy in submitting the necessary documentation to support the requested service. The timeliness parameters are in part in place to ensure beneficiaries receive the care they need in a timely manner. Additionally, repeating the review process as providers continue to submit and resubmit claims costs the Department in resources and the vendor in terms of productivity. On the part of providers, many new provider types were being routed through the prior authorization process for the first time. It took some time for those providers to acclimate to the requirements and process of prior authorization, but with time, that issue seems to be resolving itself. Providers, who once could call specific program staff and ask questions or resolve claims, are now being directed to the Provider Service Center (PSC). If providers are dissatisfied with the response of the PSC, they can file an appeal.

Communication/Provider Support

Comment: Many commenters expressed frustration with the Provider Service Center, specifically stating the PSC staff need more training. Many providers stated they did not feel their questions could be answered by the PSC staff and stated they wished to be able to speak with program staff to resolve issues.

Response: The Department has established the Provider Service Center to handle provider calls and is investing in more robust training of the PSC prior to policy changes.

Comment: Commenters also noted the lack of communication between the Department and providers, especially in the context of policy and changes to policy. One commenter noted that

providers under the Care Call system under CLTC are allotted 6 strikes for failure to check in at the client's home. However, the provider stated the definition of a strike and its relevant procedures have not been clarified for providers. An internal comment suggested the policies and procedures be contained in a searchable format.

Response: The Department is also aware that some of its policies could benefit from regular updates, revisions, and clarification. This report contains a recommendation to create a Policy area within the Department to consolidate policymaking functions. This will ensure timely and regular review of Department policies, consolidation of duplicative policies, and that changes to policy will be vetted by other functional areas in the Department, among other benefits. One goal is also to create a centrally located repository of policies and procedures with the goal of making these policies available to the public on the Department's website or through another medium. Once compiled, the Department could create a search function to aid both employees and the public with searches of policy and procedure.

Comment: Manuals are not updated in a timely manner. Often providers must search for bulletins for updates that are not included in the manuals.

Response: At this time, Medicaid manuals are scheduled for updates the month following the effective date of policy, and the Department will move to updating the manuals immediately when a new policy is effective.. At this time, the Department is reconsidering this policy as part of a larger recommendation for a policy department that would help coordinate efforts to update policy and the manuals in a more timely manner. Additionally, the Department is considering the feasibility of linking relevant bulletins to provider manuals online in order to make information more readily available to providers.

Comment: Providers undergoing audits receive little to no information for months after having submitted the requested documentation.

Response: Audit teams generally request that all information and records be available and ready to access when the team goes on site for review. Generally a short turnaround time is given to submit missing information due to fraud concerns. The Department always contacts the provider with the results of the audit. However, the Department will include in its letter of introduction (which providers receive at the onset of a review) the expected timeline for the audit and the name and contact information of the reviewer and state that the provider is free to contact the reviewer at any time to check on the progress of the review. SCDHHS is also working on an online tool, only applicable to RAC reviews, which would allow providers to check the status of their audit online.

Cost reports

Comment: An internal comment expressed concern regarding the cost reports required of providers. The commenter noted that many providers, particularly in the CLTC area, are small "mom and pop" operations that struggle with the reports. Specifically, they do not understand the forms and formulas to fill out the forms themselves, but they also have difficulty affording an accountant to prepare the reports for them.

Response: SCDHHS is currently studying the feasibility of eliminating the cost reports. Currently, the provider contracts require the provider submit a cost report. However, the information contained in the cost report is only used in an analysis when there may be changes to standard rates. It is possible that inflationary or other market data could be used to modify or set rates. The Department is working to confirm if there are any additional requirements at the federal level or from CMS that require cost reports.

Managed Care (MCOs)

Comment: Several providers expressed frustration with MCOs. Specifically, providers were displeased by the MCO's prior authorization process, differing credentialing criteria among Medicaid and the MCOs, a lack of understanding by the community and beneficiaries as to general information about MCOs, and difficulty contracting with MCOs, among others. Commenters also expressed concern with complications resulting from retroactive eligibility once an individual is enrolled in an MCO after being Fee for Service. Often the retroactive coverage is granted and an HMO is selected but it will not cover the affected visits because they are outside of the timely contractual limit for the managed care plan. Claims must then be appealed and reconsidered, adding substantial burden and expense to providers. Licensed midwives also expressed difficulty enrolling in MCOs.

Response: The Department is aware of all of the above-referenced issues and is working to address them. The MCO contract for 2014 is under review with CCIG and revisions will address many of these complaints. Options include establishing universal credentialing criteria and resolving the retroactive coverage issue, among others. As to midwives, the MCOs currently do not recognize licensed midwives but do recognize and credential certified nurse midwives. Additionally, the Department is aware of confusion among the public about how MCOs operate and the plans available. SCDHHS is currently working on provider and consumer training and education resources regarding MCOs.

Comment: One MCO submitted several comments ranging a variety of issues from SCDHHS changing policy or procedure outside the two appropriate channels identified in the MCO contract to not allowing the MCO sufficient time to implement changes, among other issues.

Response: The Department is aware of most of these issues. As stated above, the 2014 MCO contract is under consideration, and it is anticipated it will address or cover the issues stated above. The Department will seek input from its partners in making these contract revisions.

Conflict with Another State Agency's Regulations

Comment: Midwives are required by DHEC regulation (S.C. Code Regs. 61-104) to have a second licensed provider in the home during a delivery. However, Medicaid only reimburses for one provider.

Response: The Department is currently examining this issue internally to assess the feasibility of reimbursing for the services of the second provider required by DHEC's regulation.

A. BURDENS AND RECOMMENDATIONS

Note: The following section is a subset of the burdens received via internal and external submitters. SCDHHS intends to follow-up on beneficiary burdens in a Phase 2 effort, so those items are removed from the listing below. Further, general comments with no specific burdens are removed from the listing below. The full catalog of burdens received is available within the appendices.

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
Appeals		
Policy	<p>Since Keystone Peer Review Organization (KePro) began issuing prior authorizations for certain provider services, the Division of Appeals and Hearings has had a 33% spike in provider appeals. The provider appeals revolve around the same issues in general: (1) KePro refuses to even discuss the issue with the provider and instead directs the provider to file an appeal (which requires an evidentiary hearing in Columbia), or (2) the Medicaid recipient has received retroactive eligibility and the provider has requested prior authorization after receiving the notice of eligibility yet KePro denies for timeliness. The Division of Appeals and Hearings has set up over twenty (20) of these appeals and none has gone to hearing because SCDHHS Health and Medical Services has reversed KePro’s determination. This certainly leads one to think that KePro has been directed to deny prior authorizations in this manner and to make the providers jump through so many hoops via the appeals process that the providers will simply go away, and SCDHHS will save that money. Since providers are now requesting hearings in much greater numbers, it is obvious that they have figured out that if they file an appeal, SCDHHS will reverse the decision and properly pay them</p> <p>Recommendation: Train SCDHHS' agent, KePro, in such a way that it follows SCDHHS' policy when making prior authorization determinations. If that does not work, sanction KePro when they do not follow SCDHHS' policy in the work that they perform for SCDHHS and for which they are receiving a large amount of money from SCDHHS.</p>	<p>KePro does not have the authority to discuss an administrative denial which happens when the provider fails to follow SCDHHS' policy for submission of appropriate information that supports the service. Because the providers feel they have no SCDHHS contact to work with them on issues involving denials, they opt to submit an appeal. Previously providers would contact program staff to discuss issues and understand denials. KePro is performing the procedures as defined in their contract with SCDHHS which follows policy.</p>
Policy	<p>We are receiving many provider appeals related to KePro, DentaQuest & Med Solutions denials. Many of these could be related to the fact the providers are still becoming familiar with the PA process and have not followed procedures to obtain their PAs. I am not familiar with the process KePro and other contractors use but it appears when they have denied a service, they instantly direct the provider to appeal to DHHS. Issues that they could resolve like letting the provider know that a doctor's statement of medical necessity was missing, end up in appeals instead of being resolved quickly by the contractor. Another issue is there appears to be a looping problem with policy related to obtaining certain DME equipment like specialized electric wheelchairs. This is a problem that involves state and federal policy, especially when a beneficiary also has private health insurance. One example was an appeal a HASCI Waiver participant filed needing a "standing wheelchair." He was qualified for a new chair because his current chair was 10 years old. He had BC/BS insurance, Medicare, Medicaid and Waiver coverage. BC/BS denied the chair as a non-covered item. Medicare</p>	<p>The Department has invested in professional organizations to perform reviews for medical necessity. Medical necessity determinations can only be done when enough medical information is submitted to justify the need. Each time a review is repeated it is a cost to the Department in resources and to the vendor in terms of productivity. There must be parameters in place in order for the members to receive the care in a timely manner</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
	<p>will not give prior authorization and had downgraded coverage for Group 4 chairs to Group 3. The chair is very expensive so the provider does not want to order the chair without confirmation it will be paid for. Medicare & Medicaid policies prohibit paying for DME equipment until it has been delivered to the beneficiary. If a PA was issued, it does not guarantee payment. Medicaid does not want to cover the chair unless Medicare denies payment, but the provider can't order it unless he knows it will be paid for. Also Medicaid's policy often follows Medicare's about what is covered so if it is not covered by Medicare, it may not be covered by State Plan Medicaid. The HASCI waiver should cover items not covered by State Plan Medicaid, but they denied coverage and their policy states the waiver cannot pay for equipment the beneficiary already has. This means if the provider orders the chair, delivers it and then Medicare & Medicaid deny payment, DDSN will deny because he already has the chair in his home since it can take months to work through the denials from BC/BS, Medicare & Medicaid. This leaves the DME provider and beneficiaries in an impossible situation. Medicaid Policy: DME Manual pages 2-41 to 2-60 Wheelchairs, DDSN HASCI Wavier Manual, Medical Supplies, Equipment, and Assistive Technology pages 1 to 8, Medicare, Article 2/1/12 Non Medically Necessary Coverage and Payment Rules/Power Seating Systems and February 2004 CMS Article, Power Wheelchair Coverage Overview.</p> <p>Recommendation: It appears KePro, DentaQuest etc... Need to work directly with providers to resolve PA denials so if a PA is denied there is a legitimate reason and not a technical issue that could easily be resolved. For example, denial should be for things like - an MRI is not medically necessary for someone with a sinus infection instead of the provider failed to send the proof of medical necessity within 3 business days. For the wheelchair issue, DHHS & DDSN staff could create flow charts of the process required to authorize payment for equipment and see where there are continuous loops and dead ends for the providers. A review of authorization & payment policy for Medicare, Medicaid & DDSN could help identify areas that need revision or clarification.</p>	<p>when necessary. The policy for DDSN and SCDHHS can be addressed through internal discussions related to the development of the policy.</p>
42 C.F.R. 431.244(g)	<p>Not having the decisions available online in searchable format results in a substantial burden for anyone seeking to review them. Businesses as well as individuals have hearings at DHHS.</p> <p>Recommendation: SCDHHS should comply with 42 C.F.R. 431.244(g), which provides that the public must have access to all Department hearing decisions, subject to the requirements of subpart F of this part for safeguarding of information, by posting all hearing decisions in a searchable form. SCDHHS should also post decisions of the Administrative Law Court and any other judicial body considering Medicaid issues.</p>	<p>SCDHHS is in compliance with 42 CFR 431.224(g) which states the public must have access to all Department hearing decisions. These opinions are available upon request or in the Division of A&H. However, creating a searchable online database could be beneficial for providers, beneficiaries, and Department employees. SCDHHS recommends this for consideration when discussing process improvements.</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
R. 126.150-58	Recommendation: SCDHHS should review its fair hearing regulation, R. 126.150-58, for conformity with the state Administrative Procedures Act. Hearing officers should be attorneys. The regulations should include procedures for discovery.	SCDHHS' regulations are not in violation of the APA. SCDHHS recommends this for consideration when discussing process improvements with an eye toward updating our regulations and statutes. There is no requirement that hearing officers be attorneys although the Division of A&H has recently hired several contract hearing officers who are attorneys.
South Carolina Regulation, Chapter 126, Article 1, Sub-article 3	Modernize the DHHS appeal process regulation to be a less intensive and expensive process and allow a review by a separate and qualified auditor instead of the auditor denying the claim in question. *South Carolina Regulation, Chapter 126, Article 1, Sub-article 3 * The current appeal process requires a face-to-face hearing and is very costly and time-consuming for all concerned parties. * The increase in post-pay review of claims has increased the need for change.	A&H could investigate alternative methods for easing the burden on providers. For example, allow hearings to be conducted using the Department's videoconference equipment or, if necessary, by telephone.
Policy	30 day window to file and mail in appeal is too short Recommendation: Would like larger appeal window and online filing	Thirty days is a typical appeal window and provides sufficient time for providers to submit a request for appeal. Additional documentation may be submitted at the hearing and does not necessarily have to be pulled and included with the appeal request.
Audits		
Policy	Audits do not provide feedback for months.	SCDHHS generally requests that the provider to have records available for the team to review when they go on-site; these are patients' medical records which are supposed to be readily accessible. If there are pieces of the record missing, we generally give the provider only a couple of days because it could become a fraud issue. Sometimes audits do take several

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
		<p>months, but we do try to wrap up the analysis as soon as possible. PI reviewers have goals to close a certain number of cases per year and we are always working toward that. The greater problem is trying to get in touch with providers and schedule conferences with them to go over the results of the review. If the case gets referred for fraud then SCDHHS sometimes cannot communicate that. SCDHHS always contacts the provider even if the case is closed with no findings. The provider should always feel free to call the reviewer anytime to get feedback, and they are always given a name and contact number.</p> <p>However, the letter of introduction, which each provider gets on the onset of a PI review, will indicate the expected timeline and that they are free to call the reviewer anytime to check on the progress of their review, and make sure the provider has the PI reviewer's name and contact #.</p> <p>In addition, SCDHHS is working with our recovery audit contractor on a web-based provider tool where providers can go on-line and see the status of their audit. This would apply only to RAC reviews, however.</p>
Behavioral Health		

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
Policy	<p>In 2010, DHHS changed regulations around Rehabilitative Behavioral Health Services and an updated provider manual was put into effect. Prior to this change, services for therapeutic foster care were bundled allowing our staff members to document services rendered on a weekly basis. With the updated Rehabilitative Behavioral Health Services manual both our staff and foster parents need to document after each service rendered. The need for therapeutic foster parents to complete daily documentation along with the administrative duties for staff has been quite burdensome.</p> <p>Recommendation: Due to the heavy burden that unbundling the services for therapeutic foster care has caused, we would like to recommend therapeutic foster care services become bundled once more.</p>	<p>CMS advised SCDHHS to unbundle these services because it wanted to know who was rendering the services and wanted the person rendering the service to be doing the documentation in order to create more accountability. This requires both the staff member and the therapeutic foster parent to do a note for every occasion of service. If they are billing every day, then they do have to write a note every day so that documentation will match the billing. SCDHHS would have to change the way it pays for this service in order to change the documentation requirements. SCDHHS will consider potential changes to make it less burdensome</p>
Claims Processing		
	<p>Non-Claim Related Payments - We also receive calls regarding payments that the provider has received but contain no explanation as to what the payments are for.</p> <p>Recommendation: Make sure your contact list is up to date for providers and send a letter or e-mail explaining the payment.</p>	<p>When an adjustment is made to a providers account, formal communication needs to occur as is the case with the reimbursement group. To ensure all departments at SCDHHS have an understanding of adjustments outside their area, there needs to be a modification to some ongoing project. The Department needs to modify the adjustment form to include additional comments and notes. There is a Form 115 project underway that would allow for the electronic approval of adjustments in SharePoint. This additional step in the electronic approval process being completed should include the ability to research adjustments in a timely manner.</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
Policy	<p>Prior authorization process for Providers.</p> <p>Recommendation: Invest in more resources to perform post reviews and provide training/progressive reviews with those problem providers instead of making all providers jump through the hoops. Seems some providers have to be performing the appropriate procedures, so it seems wasteful to have all doing this.</p>	<p>Prior Authorizations eliminate payment for services that are not medically necessary. The Department may benefit by investing in personnel with the expertise to review medical necessity requirements retrospectively. However, the Department has made the decision to keep funds from being spent up front versus having a retrospective review to recoup payments if it is determined not medically necessary. It's more difficult to recover funds that have been generated to the provider.</p>
	<p>Exceedingly limited ICD-9 codes. Have 4 codes in ICD-9. Approximately 25 in CPT codes. Does not encompass full scope of care</p> <p>Recommendation: Crosswalk for ICD-9 to ICD-10.</p>	<p>SCDHHS is not the originator of the ICD-9/ICD-10 conversion.</p>
	<p>Cannot meet NCCI standard. Will get rejected if use code 12, which is place of service of home. Have to use code 11.</p> <p>Recommendation: Need the ability to bill a code 12.</p>	<p>The issue is the place of service. As an enrolled Birthing Center you cannot bill as "home". You must bill as an office.</p>
	<p>DHHS has a manual paper process of providing the KePRO organization with the necessary retroactive Medicaid eligibility load date which is a condition precedent to granting a retro prior authorization for a hospitalization. <i>Note: Submitter provided background and detailed discussion not included here.</i></p> <p>Recommendation: Either enhance the daily electronic report sent to KePRO to include any retroactive Medicaid eligibility load dates or provide an electronic mechanism for hospitals to be able to research the retroactive load date and provide acceptable proof to KePRO of that load date.</p>	<p>A request to have the actual date of eligibility determination posted to the member's file is in process. Staff from IT/Clemson are working through the logistics of having this information available to providers.</p>
Processing System	<p>Aged and outdated systems for claims adjudication and enrollment should be replaced for a more efficient and economical process. Aged Processing System Detail:</p> <ul style="list-style-type: none"> * Providers must often resubmit claims multiple times due to the lack of system capabilities. * NDC crosswalk is not updated timely causing extra work for providers and the Department. * Fee schedules are not updated timely causing costly payment errors that must be adjusted or reprocessed. * Reprocessing of claim batches without notice to the providers causing unnecessary and expensive 	<p>SCDHHS is currently reviewing internal manual processes for improvement. The fee schedule updates and better communication to the provider community are on the top of our list. Future projects include elimination of the Edit Correction</p>

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	<p>denials that must be resubmitted and reprocessed.</p> <p>* Edit capabilities are limited thus requiring additional staff for a manual process for claims adjudication.</p> <p>* Audits and Department funds are compromised by lack of electronic means of managing business requirements and are burdensome on providers as indicated in the following DHHS audit letter paragraph comments:</p> <ul style="list-style-type: none"> o “We have preliminary data analysis which shows that there are overpayments that were not identified and captured through the Department’s coordination of benefits processes, by the federal Medicaid Integrity Audit Contractor (MIC) audits, or by credit balance audits conducted by other audit firms.” o “We recognize that for some patient accounts the hospital may have already identified the overpayment and refunded DHHS. However, these refunds do not show up in our claims data since the individual claim is not adjusted on a post-payment basis.” o “The time frame for this review will begin with May 2011 and will continue as we get new paid claims data. The Hospital Services Provider Manual was updated on September 1, 2011 to reflect SCDHHS payment policy. MMIS does not have the capacity to correctly process the claim. It is our intention to conduct this audit on an ongoing basis until the MMIS system can be corrected.” 	<p>Forms and developing a process to submit electronic claim attachments. The NDC Cross walk is updated monthly in conjunction with the NDC/HPCPS national crosswalk. However, we are aware that there are situations where the NDC is not loaded on the crosswalk prior to claim submission. Providers are asked to submit the label of the drug along with the claim for review.</p> <p>SCDHHS changed the policy in the provider manual a couple of years ago, but system changes in MMIS for the UB claims have yet to be made, although they were made for professional claims. This request has been in the queue for some time, but it diverted when the Department started making plans to replace the MMIS.</p>
KePro Retro-enrollment Process	<p>Retro-enrollment and the KePro prior authorization process. KePro needs access to the actual date of retro-enrollment approved for Medicaid recipients in order to prevent the burden of requiring a hospital to provide documentation of the DHHS process. The lack of system capability is the cause of unnecessary denials of hospital admissions and duplicate work on behalf of hospitals, KePro and DHHS. DHHS acknowledged a correction process to this burdensome arrangement last summer but does not have a date of completion.</p>	<p>A request to have the actual date of eligibility determination posted to the member's file is in process. Staff from IT/Clemson are working through the logistics of having this information available to providers.</p>
	<p>The Medicaid Provider Manuals that govern the practice should be referenced when looking at the following comments.</p> <p>The specific process of obtaining authorizations for clients is cumbersome and time consuming. I am only allowed to take clients who are referred to me by another LPHA, specifically a physician. The physician signs off for the initial assessment, faxes to another Department, not Medicaid, for an authorization just for the assessment. That is the first authorization. Then a Medical Necessity Form is required for the second authorization for treatment. Again the process starts with the clinician filing out the form, faxing to the physician to sign, fax back, then it is faxed to the outside Department for authorization, not Medicaid. (If a clinician is on an insurance panel, most companies that require</p>	<p>1. Current policy states that an LIP (Licensed Independent Practitioner) has to receive a referral from a physician or state Department in order to provide therapy services. The referral process requires that the physician send the LIPS referral form to KePro to authorize the initial assessment. KePro then sends the LIP an approval letter if referral is</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
	<p>authorizations are one phone call or one form to obtain a certain number of visits for treatment and you are done.)</p> <p>Medicaid also requires an inappropriate amount of paperwork for completion of the file. Medicaid also requires separate meetings for treatment plan formulation, invitations in the file to other parties involved for the formulation of goals. The client, family and the clinician should be all that is required for the formulation of goals of treatment. If the family is bringing the client to treatment why does there need to be an invitation to a meeting to formulate goals that they are already a part of? The goals do not need to be in a separate form (IPOC) when they can be specified in the progress notes (CSN). The completion of these additional forms and/or other paperwork takes away from the treatment of the client, plus the clinician is not reimbursed for the extra time for completion of the forms. (Insurance companies do not require this amount of paperwork or complication.)</p> <p>Recommendation: Please streamline the authorization process and required paperwork. Each of these two parts can be done in a more efficient manner. One phone call to a Medicaid representative to give an authorization for an assessment and a certain number of visits would be adequate. Much of the paperwork could be incorporated into the progress notes without additional forms or requirements.</p>	<p>approved. After the LIP completes the assessment, the LIP must send the assessment to the physician who then completes the MNS and sends to KePro again for authorization for further services. This is already being looked at for possible change in order to reduce hassle factors as well as to comply with Mental Health Parity Law.</p> <p>2. LIP Policy does require an Individualized Plan of Care (IPOC) be completed for each client within 45 calendar days. Policy states: "Excluding assessment services, an IPOC should be developed prior to delivery of services with the full participation of the beneficiary and his or her family, if appropriate, unless in case of emergency". Also, "Multiple Department staff or members of an interdisciplinary team must participate in the process of developing, preparing, and/or reviewing the IPOC in order for the LIP to provide the service." However, it is perfectly acceptable for the provider, beneficiary and family to be the only ones on this team (especially in a setting that does not have an interdisciplinary team). The IPOC is required to be separate from the CSNs (clinical service notes) as these document services such as individual, group, or family therapy. These policies could be evaluated to determine how to reduce the burden of this documentation.</p>

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<p>SC Medicaid Manual, Section 6, dated 10/01/12, and the SC Medicaid bulletins dated 07/09/12 and 12/12/12.</p>	<p>The Birth Outcomes Initiative policy that Medicaid implemented to be effective 01/01/13 has caused our practice a huge negative impact. We have not been paid on any delivery claims since 01/01/13 for patients that delivered prior to 39 weeks. The bulletin asks for practices to submit Medicaid approved diagnosis codes and report the appropriate modifier. Not in any bulletin or policy did it say this would require the provider to send hard copy documentation along with the claim or the documentation needed to be sent with the error correction forms the claims would generate. SC Medicaid is notorious for denying claims as untimely due to the documentation not being reviewed with the claims. Our office has lost thousands of dollars in past years after sending documentation repeatedly for the same claim for it to have to be written off as untimely, regardless if the office can provide proof of timely filing. If delivery claims need to be processed with the same procedure and there are no more trained staff members at Medicaid to process these claims quicker, there will be an increase in untimely denials that our office cannot continue to support.</p> <p>I went to Medicaid last week to meet with the appropriate person regarding these issues. Again; to date, these issues are still not resolved. It is very concerning that it is three and a half months after both of these new policies were enforced, and there is still no procedure in place to correct the problem.</p>	<p>This issue was identified as an internal error and claims have been reprocessed. Providers received an alert that they should receive payment by May 3, 2013.</p>
<p>Procedure code J1055 was deleted/replaced with J1050</p>	<p>On another topic where SC Medicaid is impacting our practice negatively: three and half months after the Depo-Provera procedure code J1055 was deleted/replaced with J1050, there is still not a way to report this to Medicaid. There is no procedure in place to do so. A patient receives 150mg for contraceptive purposes. The new/replaced code only reports 1 mg.</p> <p>I went to Medicaid last week to meet with the appropriate person regarding these issues. Again; to date, these issues are still not resolved. It is very concerning that it is three and a half months after both of these new policies were enforced, and there is still no procedure in place to correct the problem.</p>	<p>This issue was discussed and addressed during the provider's visit with Medicaid. The pricing files have been updated; claims have been recycled to adjust payment to providers.</p>
	<p>KePro. There continues to be some problem with the implementation of KePro as the prior authorization entity. Providers report that complying with KePro's information submission timelines is often difficult to execute and once in, response from KePro is sometimes slow. This creates a burden for providers in terms of the time and resources expended to comply and then can result in an additional financial burden to the hospice as they continue to provide the full range of hospice service while they await a determination from KePro.</p> <p>Recommendation: Encourage/require KePro to meeting with the hospice industry to share and address these concerns. Please note: The Carolinas Center has attempted but been unsuccessful in facilitating such a meeting through our contact with KePro.</p>	<p>This issue has been addressed through a conference call with KePro staff and the submitter. The submitter will share information with the Hospice community.</p>
	<p>ECFs require lots of manual work. Some of the ECFs generated are a result of system updates that</p>	<p>Currently SCDHHS is working on a</p>

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	<p>have not been loaded.</p> <p>Recommendation: Medicaid should look at new technology and make more timely system updates or eliminate ECFs.</p>	<p>process to eliminate ECFs by year end.</p>
	<p>Very manual process to file EMS claims. Have to manually key entire claim through web tool. Clearinghouse requires certain documentation for 837i that isn't there.</p> <p>Recommendation: Match EDI requirements to web tool</p>	<p>Will take this recommendation under advisement.</p>
	<p>Different requirements for Medicaid and Medicare claims processing.</p> <p>Recommendation: State should follow federal guidelines and mirror edit process</p>	<p>Will take this recommendation under advisement.</p>
	<p>KePro gives multiple numbers and DHHS only accepts 1.</p> <p>Recommendation: Would like a program representative and increased training for provider service center.</p>	<p>KePro only assigns one number per claim. Any instances where KePro is assigning multiple numbers would be the result of the submission of multiple claims.</p>
	<p>Hard to get explanation of claim denial.</p> <p>Recommendation: Would like specific details on denials</p>	<p>Will communicate concerns with the current dental ASO and solicit recommendations for improvement if applicable.</p>
	<p>Requirement to submit original paperwork when original paperwork is scanned and then trashed.</p> <p>Recommendation: Would like to submit scanned copies</p>	<p>Staff is currently reviewing all SCDHHS Medicaid Hospice forms and policy to better align current processes with Medicare's. Staff will continue to work with association leadership and providers to seek input. Staff is examining online submission.</p>
	<p>Doctors' offices call to complain about the turnaround time of payments.</p>	<p>Need more information on this one. This could be contributed TP provider billing issues, policy interpretation, or a system issue.</p>
Community Long Term Care		

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
New TCM Guidelines	<p>Home visits would put a strain on our Department because it requires that two staff members go out on each visit. Many of our clients live in unsafe neighborhoods. Our staff is not equipped to make such trips, and we do not have sufficient staff to be able to send two staff members on each trip. Also, these trips are very time-consuming in general.</p> <p>Recommendation: Remove the requirement in the new TCM Guidelines to have an in home visit within 6 months before you are able to bill these codes</p>	<p>Under the new TCM guidelines for the Department of Alcohol and Drug Abuse there is a Medicaid requirement that says in order to bill Case Management that the provider must do an in home visit within the first 6 months. This was not required in the past.</p>
	<p>CLTC Providers - Contractually, these providers are bound to file annual cost reports for their ADHC (Adult Day Care), PC I and II (Personal Care Aide) and Medicaid Nursing services. Many times we hear quite a bit of grumbling about the preparation of these reports. These are small "mom and pop" enterprises many times, and they state that the Medicaid program does not offer payments great enough to afford an accountant to prepare these reports. Thus, they complete the reports themselves, struggling to understand our financial formulas. These folks are generally clinical in background. To compound their frustrations, these are used only for rate setting purposes and not cost settlement, so they do not see an immediate or financial gain for their efforts.</p> <p>Recommendation: We are currently evaluating the necessity and practicality of these reports given alternative means of justifying the CLTC rate structure.</p>	<p>The contracts that the provider signs require a cost report to be completed. This data is only used for analysis when there may be changes to the standard rates. It would be possible to use inflationary data or other market data to modify this rate. The Department is in the process to determine if there is a cost report requirement from CMS regarding this waiver service.</p>
	<p>Recently, the federal government made it mandatory for persons who receive incontinence supplies to have a medical order from the doctor in the chart. I would say the majority of participants in our program need incontinence supplies. These were sent out 3-15-13 to all doctors. I don't know that doctors will sign these as some may not even know, for sure, if their patient is incontinent. Also, I feel the doctors who are presently being bombarded with these forms are going to charge Medicaid for every form they are required to sign. And, this has to be repeated each year--365 days from now on for each participant. This is a burden on us and is costing Medicaid a lot of money. My participants do not like to talk about their problems, but I can assure you the people I deal with need the supplies.</p>	<p>Incontinence supplies are now covered under the mandatory Medicaid State Plan Home Health benefit. Per 42 CFR 440.70(b)(3)(i) and (ii), a recipient's need for medical supplies, equipment, and appliances must be reviewed by a physician annually. Frequency of further physician review of a recipient's continuing need for the items is determined on a case-by-case basis, based on the nature of the item prescribed.</p>
	<p>With CPCA cases, the mothers desire more flexibility for use of hours.</p> <p>Recommendation: If hours could be authorized for the week instead of day by day, the families would have more flexibility.</p>	<p>SCDHHS will review this suggestion, but at this time PC II services are day specific to ensure service plan needs are met.</p>

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	<p>I think the Policy and Procedure Manual for CLTC could be rewritten to be more specific and less wordy. It is a regulatory burden in itself in many ways.</p>	<p>CLTC will include this suggestion in its policy reviews. Due to the varied and many program/waiver requirements, the policy/procedure can be necessarily involved. We will consider ways to streamline where possible.</p>
<p>Medicaid Nursing Home Permit Program; Proposed Statute; Proposed Medicaid Nursing Home Permit Revision Bill</p>	<p>The statute was originally passed in the mid-1980s in order to manage the growth of Medicaid skilled nursing home expenditures. Prior to its passage, the General Assembly enforced a CON moratorium on new skilled nursing facilities wishing to participate in Medicaid. The purpose of the moratorium was to enable the Medicaid Department to implement the Community Long Term Care (CLTC) program, a new home and community-based service alternative for individuals who qualified to skilled nursing facility admission under Medicaid and desired to age in place and receive their long term care services in their own home. This program started in 1984.</p> <p>Implementation of the permit day program effectively grandfathered in existing facilities and, over the last 25 years, has limited new skilled nursing facilities' ability to participate in the program. Additional criteria for participation, such as measures of quality of care, patient preference and purchasing value, and a contracting process that does not allow open enrollment for any willing provider and bidding have not been incorporated into the contracting process.</p> <p>The current system negatively impacts South Carolina's Medicaid population in several ways. First, introduction of quality measures in the contracting process would assure that the state and Medicaid eligible skilled nursing residents are receiving the highest value and quality of care for the Medicaid expenditures. Second, the current system requires a skilled nursing resident who resides in a non-participating facility to re-locate to another facility when they outlive their resources and become Medicaid eligible for skilled nursing facility services. These transitions often are very detrimental to the residents' health and safety and adversely affect life expectancy.</p> <p>Recommendation: Maintain the Current Law for FY 14 and Repeal in FY 15</p> <p>The Medicaid Nursing Home Permit program has been successful in controlling the number of Medicaid eligible nursing home residents served each year. Changes (increases and decreases) in this number have occurred in accordance with the number of days authorized in the annual state budget. For example, in 1997 the average daily census of Medicaid skilled nursing facility residents was 11,160. Five years later in 2002, the number had increased to 12,154, and in 2012 the average daily census was 10,416.</p>	<p>SCDHHS continues to work with stakeholders (SCDHEC, providers, provider associations and advocacy groups) on addressing the Medicaid Permit Day Law and its impact on bed availability in South Carolina. Proposed revisions for the SFY 14 Permit Day Proviso include but are not limited to: Following the initial allocation of Medicaid patient days, any additional Medicaid permit days will be credited to a statewide pool and the days will be allocated to those counties showing the greatest need based on the average number of fully eligible Medicaid nursing facility applicants by County in the Community Long Term Care awaiting placement reports. The Department of Health and Human Services shall provide this information to the department no later than July 15 of each year. The Medicaid permit days must be proportionately allocated to each facility within the county that currently holds a Medicaid permit and is currently in compliance with its Medicaid permit. A facility is deemed to be in compliance for allocation of these additional Medicaid permit days</p>

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	<p>Over this same time period, the state’s Medicaid policy goal was to increase access to home and community-based services for those individuals requiring long term care services. As a result, Community Long Term Care’s average daily census has grown from 6,269 in 1997, to 11,011 in 2002 and to 12,106 in 2012.</p> <p>Another long term care system change which will significantly impact provision of the state’s Medicaid long term care services will be implementation of the South Carolina Dual Eligible Demonstration Project – SC DuE. Under this project, beginning in the fall of 2013 approximately 65,000 non-institutionalized dually eligible individuals will be enrolled in managed care organizations (MCO) and will begin receiving all Medicare and Medicaid services through the MCO in January 2014. Ninety days of skilled nursing facility services and all CLTC services will be included in the benefit package and capitation payment rate. MCOs will have the ability to introduce appropriate criteria for selecting and contracting with skilled nursing facility and CLTC providers. As more Medicaid eligible South Carolinians age and become frail and disabled in the future, growing numbers of the MCO members will become eligible for long term care services.</p> <p>In addition to the increased availability of home and community-based services and implementation of the SC DuE project, dually eligible South Carolinians also have access to long term care services through the state’s two Program of All-inclusive Care for the Elderly (PACE), which are located in Orangeburg, Richland and Lexington Counties.</p> <p>South Carolina’s Medicaid nursing home permit program is unique among the nation’s Medicaid programs. And, while it has been effective in the past, the permit program is not compatible with the changes in the health care financing and delivery systems and the state’s Medicaid policy goal to increase the availability of alternative systems for accessing Medicaid-sponsored long term care services.</p> <p>FY 14 will be a year of transition for the Medicaid program. Lutheran Homes of South Carolina recommends that during this year a) the current Medicaid Nursing Home Permit program and statute remain unchanged and b) appropriate inter-Department and provider groups begin a collaborative process to develop recommended revisions to state long term care policy for consideration by the SC General Assembly in January 2014.</p> <p>Further, Lutheran Homes of South Carolina recommends repeal of the current Medicaid Nursing Home program statute for the state fiscal year effective July 1, 2014.</p>	<p>if it has not exceeded its stated Medicaid permit by more than seven percent. In addition, a nursing home that provides less than ninety percent of the stated Medicaid permit in any fiscal year may not apply for additional Medicaid permit days in the next fiscal year. If a nursing home fails to provide ninety percent of the stated Medicaid permit number for two consecutive fiscal years, the department may issue a Medicaid nursing home permit for fewer days than requested in order to ensure that the nursing home will serve the minimum number of Medicaid patients and that the State will optimize the available Medicaid days. Following the initial allocation of Medicaid patient days, any additional Medicaid permit days will be credited to a statewide pool and the days will be allocated to those counties showing the greatest need based on the average number of fully eligible Medicaid nursing facility applicants by County in the Community Long Term Care awaiting placement reports for the past 12 months. A nursing home receiving beds under the provision of Section (C) shall not be Special Focus Facility at the time of allocation. Please note: Since the proposed language has not been voted upon, approved and/or ratified, final outcome is pending.</p>

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<p>Medicaid Nursing Home Permit Program</p>	<p>Impact of Statute: The statute was originally passed in the mid-1980s in order to manage the growth of Medicaid skilled nursing home expenditures. Prior to its passage, the General Assembly enforced a CON moratorium on new skilled nursing facilities wishing to participate in Medicaid. The purpose of the moratorium was to enable the Medicaid Department to implement the Community Long Term Care (CLTC) program, a new home and community-based service alternative for individuals who qualified to skilled nursing facility admission under Medicaid and desire to age in place and receive their long term care services in their own home. This program started in 1984.</p> <p>Implementation of the permit day program effectively grandfathered in existing facilities and, over the last 25 years, has limited new skilled nursing facilities' ability to participate in the program. Additional criteria for participation, such as measures of quality of care, and a contracting process that does not allow open enrollment for any willing provider and bidding have not been incorporated into the contracting process.</p> <p>The current system negatively impacts South Carolina's Medicaid population in several ways. First, introduction of quality measures in the contracting process would assure that the state and Medicaid eligible skilled nursing residents are receiving the highest value and quality of care for the Medicaid expenditures. Second, the current system requires skilled nursing residents who reside in a non-participating facility to re-locate to another facility when they outlive their resources and become Medicaid eligible for skilled nursing facility services. These transitions often are very detrimental to the residents' health and safety and adversely affect life expectancy.</p> <p>Alternative: Maintain the Current Law for FY 14 and Repeal in FY 15</p> <p>The Medicaid Nursing Home Permit program has been successful in controlling the number of Medicaid eligible nursing home residents served each year. Changes (increases and decreases) in this number have occurred in accordance with the number of days authorized in the annual state budget. For example, in 1997 the average daily census of Medicaid skilled nursing facility residents was 11,160. Five years later in 2002, the number had increased to 12,154, and in 2012 the average daily census was 10,416.</p> <p>Over this same time period, the state's Medicaid policy goal was to increase access to home and community-based services for those individuals requiring long term care services. As a result, Community Long Term Care's average daily census has grown from 6,269 in 1997, to 11,011 in 2002 and to 12,106 in 2012.</p> <p>Another long term care system change which will significantly impact provision of the state's</p>	<p>SCDHHS continues to work with stakeholders (SCDHEC, providers, provider associations and advocacy groups) on addressing the Medicaid Permit Day Law and its impact on bed availability in South Carolina.</p> <p>Proposed revisions to the SFY 14 Permit Day Law include the following, but not limited to: Following the initial allocation of Medicaid patient days, any additional Medicaid permit days will be credited to a statewide pool and the days will be allocated to those counties showing the greatest need based on the average number of fully eligible Medicaid nursing facility applicants by County in the Community Long Term Care awaiting placement reports. The Department of Health and Human Services shall provide this information to the department no later than July 15 of each year. The Medicaid permit days must be proportionately allocated to each facility within the county that currently holds a Medicaid permit and is currently in compliance with its Medicaid permit. A facility is deemed to be in compliance for allocation of these additional Medicaid permit days if it has not exceeded its stated Medicaid permit by more than seven percent. In addition, a nursing home that provides less than ninety percent of the stated Medicaid permit in any fiscal year may not apply for additional Medicaid permit days in the next fiscal</p>

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	<p>Medicaid long term care services will be implementation to the South Carolina Dual Eligible Demonstration Project – SC DuE. Under this project, beginning in the fall of 2013 approximately 65,000 non-institutionalized dually eligible individuals will be enrolled in managed care organizations (MCO) and will begin receiving their entire Medicare and Medicaid services through the MCO in January 2014. Ninety days of skilled nursing facility services and all CLTC services will be included in the benefit package and capitation payment rate. MCOs will have the ability to introduce appropriate criteria for selecting and contracting with skilled nursing facility and CLTC providers. As more Medicaid eligible South Carolinians age and become frail and disabled in the future, growing numbers of the MCO members will become eligible for long term care services.</p> <p>In addition to the increased availability of home and community-based services and implementation of the SC DuE project, dually eligible South Carolinians also have access to long term care services through the state’s two Program of All-inclusive Care for the Elderly (PACE), which are located in Orangeburg, Richland and Lexington Counties.</p> <p>South Carolina’s Medicaid nursing home permit program is unique among the nation’s Medicaid programs. And, while it has been effective in the past, the permit program is not compatible with the changes in the health care financing and delivery systems and the state’s Medicaid policy goal to increase the availability of alternative systems for accessing Medicaid-sponsored long term care services.</p> <p>Recommendation: FY 14 will be a year of transition for the Medicaid program. Leading Age SC recommends that during this year a) the current Medicaid Nursing Home Permit program and statute remain unchanged and b) appropriate inter-Department and provider groups begin a collaborative process to develop recommended revisions to state long term care policy for consideration by the SC General Assembly in January 2014.</p> <p>Further, Leading Age SC recommends repeal of the current Medicaid Nursing Home program statute for the state fiscal year beginning July 1, 2014.</p> <p>Proposed Statute: SC Health Care Association’s Proposed Medicaid Nursing Home Permit</p>	<p>year. If a nursing home fails to provide ninety percent of the stated Medicaid permit number for two consecutive fiscal years, the department may issue a Medicaid nursing home permit for fewer days than requested in order to ensure that the nursing home will serve the minimum number of Medicaid patients and that the State will optimize the available Medicaid days. Following the initial allocation of Medicaid patient days, any additional Medicaid permit days will be credited to a statewide pool and the days will be allocated to those counties showing the greatest need based on the average number of fully eligible Medicaid nursing facility applicants by County in the Community Long Term Care awaiting placement reports for the past 12 months. A nursing home receiving beds under the provision of Section (C) shall not be Special Focus Facility at the time of allocation. Please note: Since the proposed language has not been voted upon, approved and/or ratified, final outcome is pending.</p>
	<p>CLTC doesn't know all of their policies.</p> <p>Recommendation: Need to have access to information in order to answer questions.</p>	<p>CLTC staff will receive continuing and ongoing training in policies for all staff members.</p>
Dental		
	<p>DentaQuest takes up to 3 weeks for authorization for hospital dental visits.</p>	<p>The Department has contracted with DentaQuest to manage its dental</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
	Recommendation: Focus on dentists who don't follow rules. Don't make everything go through DentaQuest. Remove authorization.	program. This contract is up for renewal next year and options for staying with an ASO or moving to another model are being considered at this time.
	Would like to treat patients based on actual needs rather than limits by age requirements for dental services.	Will review the current policies by which the dental ASO administers the program.
	Many dentists are on precipice of dropping Medicaid	The current dental ASO is termed to expire in 2014. The Department is in the process of soliciting comments and recommendations for options other than an ASO model.
	No follow-up from DentaQuest on potential improvements.	Will communicate concerns with the current dental ASO and solicit recommendations for improvement if applicable.
Eligibility		
	<p>Most SCDHHS "Notices of Adverse Action" do not comply with 42 CFR § 431.210. Eligibility "Notices of Adverse Action" will typically list the specific regulations that support the action as, "102.06.01." While the eligibility staff may know that this refers to a section of the SCDHHS Medicaid Policy and Procedures Manual, I find it hard to believe that anyone not associated with Medicaid Eligibility would know to what these 7 numbers refer. The typical SCDHHS Community Long Term Care Notification Form lists no specific regulation that supports the negative action. 42 CFR § 431.210 is written to ensure that a Medicaid applicant or recipient can readily determine the policy that directs the negative Medicaid action and in that way, can be prepared to appeal that determination or accept that determination. By not following federally mandated regulations, SCDHHS is causing more work for its staff and, on its face, intentionally preventing Medicaid applicants and recipients from understanding how Medicaid works.</p> <p>Recommendation: Change SCDHHS' notices to comply with federal Medicaid policy.</p>	SCDHHS major third parties (KePro, MedSolutions, Magellan) include federal regulation language in their notices. SCDHHS will ensure the notice procedures are consistent throughout the Department.
	The current DHHS Form 181 process is an unnecessary burden for vendors and eligibility staff. Although the DHHS Form 181 was recently revised to be form fillable, which improved processing somewhat, the entire process should be reviewed and simplified. Currently, the vendors email, fax or mail the forms to the local eligibility office then continually call to check the status of those forms. The eligibility office reviews the form and if needed authorizes, terminates, or make changes to the vendor payment and returns the form to the vendors. Once received, the vendors submit the forms to	Automating the billing process will correct many of the concerns expressed. If recurring income is properly stored and available electronically, this would eliminate the need for SCDHHS Form 181. A

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	<p>third party billing to process the claims. That third party then has to decipher the information on the forms and submit for payment. This process just seems antiquated to me. Because we are currently in the process of revamping our antiquated MMIS mainframe and our Medicaid Eligibility Determination (but not really, because it's just a storehouse of data) System, I think now would be a good time to incorporate the vendor payment process into the system making it completely electronic. MPPM 304.23DHHS Form 181 (Notice of Admission, Authorization and Change of Status for Long-Term Care) (Eff. 01/01/10) The DHHS Form 181, Notice of Admission, Authorization, and Change of Status for Long-Term Care, is the form used by nursing facilities to bill Medicaid for a vendor payment. Eligibility workers and nursing facilities use it to communicate information about:</p> <ul style="list-style-type: none"> • Approvals • Changes such as: Transfers to another facility; Admissions to or re-admissions from a hospital; Level of Care changes; Increases or decreases in recurring income; Terminations due to such things as: <ul style="list-style-type: none"> o Death of beneficiary o Expiration of bed hold • Medicare-sponsored admissions • Medicare terminations • Denials of applicant/beneficiary is denied for Medicaid or Vendor payment eligibility, one of the following reasons must be shown on the DHHS Form 181: <ul style="list-style-type: none"> § You failed to meet financial eligibility § You failed to meet non-financial eligibility § Vendor Payment denied, eligible for Medicaid card only <p>Recommendation: I think now would be a good time to incorporate the vendor payment process into the MMIS and Eligibility determination systems making it completely electronic. The DHHS form 181 should only be used at initial determination for vendor payment. The names of all of the approved nursing home beneficiaries should be in an electronic system that the vendors, eligibility, and third party billing can access. The vendors should be able to update this system whenever there is a change in the beneficiary's status. Whenever there is a status change that requires eligibility to approve, the eligibility office/worker should receive an alert. The eligibility worker should be able to go to the system and enter a code for approval or make any necessary changes to recurring income. The vendor can then get an alert to review and submit to third party for payment.</p>	<p>Department group is currently looking at the claim processing practices for nursing homes.</p>
	<p>Recommendation: SCDHHS should promulgate regulations about key provisions of Medicaid waivers, including eligibility criteria. Businesses that provide services through the waivers, as well as individuals, will benefit from being able to participate in the regulatory process. See for example Virginia regulation. See Vermont regulation.</p>	<p>SCDHHS will continue to investigate this issue.</p>

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	<p>Pendleton Place for Children and Families is concerned about the termination of Medicaid benefits for parents whose children have entered custody of South Carolina Department of Social Services. Our stance is that discontinuing Medicaid prevents the caregiver from following through on court ordered mental health or substance abuse counseling.</p> <p>Recommendation: Therefore, we recommend continuing parental or caregiver Medicaid benefits up to one year upon removal of a child or children. This will assist in removing barriers for parent(s) not able to access or afford court ordered treatment which impedes efforts made by all Child and Family Welfare Service entities across the state of South Carolina in regard to improving safety, well-being and reunification for children, Parent(s) and families, in general.</p>	<p>This has already been identified as a problem, and there is a meeting to discuss this eligibility issue on April 25, 2013 with Eligibility and Behavioral Health staff. This issue has been brought up related to the Family Care Centers that DSS and DAODAS are starting.</p>
	<p>Many of our patients are under the impression that we get paid our full fees by Medicaid and that we are getting rich by providing healthcare services to Medicaid patients. We actually lose money every time we see a patient with Medicaid, as our office is not set up to profit from Medicaid. We don't double book appointments, and the dentist allows parents back with their children and spends time talking to each patient AND parent. For this reason, we are limited to how many Medicaid patients we can see and have strict rules about no-shows and/or not following through with recommended treatment. Every time there is a rate reduction in the fee schedule, we accommodate this by decreasing the number of Medicaid patients we can see. Every time the amount of paperwork for appeals and authorizations goes up, we decrease the number of patients we can see. As other costs go up, that also affects how much Medicaid we can see as our way of "giving back to the community" or "charity work."</p>	<p>There is no regulatory burden identified in this item.</p>
	<p>We are at full capacity with our schedule, so we have blocked off certain days and times to see Medicaid. The main reason we do this is because Medicaid insurance is different than all the others in that everything falls on us to be sure their insurance is active, that they haven't been to another office since their last visit, and that certain codes are only billed at certain ages. If anything gets denied because of these things, we take the loss (versus non-Medicaid where the parent is responsible and it's between them and their insurance to fight about). Patients get mad at us for only scheduling on Thursday mornings and get more upset when we don't reschedule their broken appointments. Our analogy is when Chick-Fil-A has "free chicken sandwich day," they have the supplies and resources to give out free chicken sandwiches set aside for that particular day. If you don't show up, you can't go back a week later and demand your free chicken sandwich because you failed to show up on the correct day.</p>	<p>There is no regulatory burden identified in this item.</p>

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	<p>We make it a policy at our office to never judge someone based on a sample pool of n=1. If someone on Medicaid has a \$40,000 car, we don't know how they got it (grandpa may have paid for it, they may have won it, they may have bought it before losing a job, they may rebuild cars, etc.). But we also keep up with trends. So when dozens and dozens of patients on Medicaid roll up in \$40,000+ vehicles, we know there is something terribly wrong with the algorithms in place for determining Medicaid eligibility. Apparently there are a lot of people that don't have the money for their "needs," but have plenty for their "wants." When speaking with colleagues that don't accept Medicaid any longer, but have at some point in their past, this is the most common justification we hear for never taking it again – "I got tired of seeing my patients rolling up in nicer cars than I drove (or could afford if they were a young dentist/doctor) to get their free work done."</p>	<p>There is no regulatory burden identified in this item.</p>
	<p>We only have two ladies answering the phones at our office, and they also check patients in and out, confirm appointments, run the front desk, and help out as needed in other areas. We are no longer accepting new patients with Medicaid insurance, but are still a provider for our current patients and those with special needs. They don't have the time to take all the calls we get wanting to schedule an appointment with Medicaid that find out about us from their case worker or provider list. There needs to be a more sophisticated list that specifies: accepting new patients, no longer accepting new patients, only taking patients under 6 years old, only accepting patients with special needs, etc. This would save time for employees at offices that accept Medicaid and be less of a hassle for parents looking for an office that is taking new patients. I am worried that if Medicaid is expanded to thousands more children, this problem will only become worse and will happen all at once, causing many offices to drop out completely.</p>	<p>There is no regulatory burden identified in this item.</p>
	<p>There needs to be a second tier of Medicaid for those that make a certain amount of money or value good healthcare, but may have trouble paying full fees. It could be called Medicaid Premier and pay at a fee schedule 20-30% higher than the current one, but with 50% of the responsibility on the member. For those with Medicaid as secondary insurance, they may still not have to pay anything. This would be a win-win-win: patients pay a discounted rate on healthcare; Medicaid pays out 35-40% less on claims, and the providers receive 20-30% more on their EOBs. It would also free up more appointments in offices set up to take Medicaid as it currently stands and offices that don't currently accept Medicaid now may be open to accepting Medicaid Premier. It would also keep Medicaid from being an all or nothing program and more people on Medicaid would make it a goal to get off Medicaid without the worry of losing an insurance that pays everything or nothing.</p>	<p>Taken under advisement.</p>
	<p>Allow offices to require deposits to reschedule a broken appointment. You don't have to allow broken appointment penalty fees, but do allow a deposit to be required if the patient misses an appointment. Patients with a history of a broken appointment are far more likely to have another one than someone who hasn't. This is why many offices won't reschedule those without some type of commitment up front. Some may be willing to pay this deposit to avoid having to wait 6 months to get in at another office, and as long as they show up, they get it back.</p>	<p>Taken under advisement.</p>

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	<p>Broken appointments are much higher in Medicaid population.</p> <p>Recommendation: Accountability for beneficiaries</p>	<p>Taken under advisement.</p>
	<p>Create 2nd level of Medicaid with copay</p>	<p>Taken under advisement.</p>
	<p>I am a hospital outstationed worker, and I discussed this response with Billing management. This was the response. Policy unduly burdens the provider when Medicaid authorizations are required because they are time consuming. Also the policy unduly burdens the provider to have to require retro letters DHHS Form 945 for resubmission for Medicaid payment.</p> <p>Recommendation: Possible alternative would be to not require authorizations nor form 945 retro letters.</p>	<p>The requirement of form 945 to support a retro eligibility has been removed.</p>
	<p>Our government is all over the place, and we as taxpayers and citizens, whether we pay little or lot, the money that is needed will not be allocated for the state. So without taking the money or assessing the true problems in our state government, problems will arise more and more and come back. See we are expected to do the work but not get paid for doing the work. They have burdened us with the rules and regulations, but they do not abide by the law as well.</p> <p>Recommendation: Need to have workers in place that abide by the rules and have higher management backing us on the decisions. I have learned we can do our job right all day, but someone will always be unhappy with it.</p>	<p>SCDHHS contacted the submitter on 3/26/13 requesting specifics related to a statute, regulation, rule and/or policy. Following is the submitter's response, which did not provide specifics as requested. "Regulations play an indispensable role in protecting public health, welfare, safety, and our environment, but they can also impose significant burdens and costs. During challenging economic times, we should be especially careful not to impose unjustified regulatory requirements. For this reason, it is particularly important for agencies to conduct retrospective analyses of existing rules to examine whether they remain justified and whether they should be modified or streamlined in light of changed circumstances, including the rise of new technologies, reducing administrative burdens, minimizing compliance costs (costs enterprises incur to comply with the rules); preventing more rules, for example by</p>

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		checking legislative proposals in advance for inopportune rules; improving public services, e.g. by introducing electronic files for entrepreneurs; focusing inspections on high-risk enterprises, identifying problems sector by sector in cooperation with entrepreneurs and employers' organizations. SC has a failing grade on healthcare and education there has to be money allocated to the State that will help not hurt."
General		
	Perhaps we should have a permanent standing committee to review regulations.	Refer comment to Office of the Governor task force.
	<p>Administrative burdens on providers and vendors; providers are burdened by repetitive requests for similar information</p> <p>Recommendation: Create a Centralized Repository Vault. Current regulatory authorities or state agencies with compliance responsibilities impacting providers or vendors should pursue a <i>Centralized Repository Vault</i> or <i>Document Vault</i>. This is an electronic vault into which providers/vendors upload key documents that are most often requested by state licensing/monitoring entities. Once the documents are uploaded, state Department personnel are required to use the vault to review the provider's/vendor's Department information. The provider/vendor has the right to refuse copies or pull documents that are in the electronic vault.</p> <ul style="list-style-type: none"> • The vault can save administrative time and promotes efficiency. Agencies must assign personnel to upload documents and to assure that affected parties understand what has been “deposited” into the vault. Providers/vendors are required to assure all documents are current. • A centralized repository vault eliminates duplication of government services allowing providers to focus on direct provision of care. • Provider agencies must have assurances that budgets containing detailed salary information are protected, so the need to control access into the vault is essential. • The vault streamlines reporting to the state’s human service agencies and eliminates duplication of services, providing more efficient monitoring. Compliance or regulatory staff can review much of the important documents prior to on-site visitation, saving administrative time at the site. • Authorized personnel of community service providers that are currently under contract with a state 	<p>A vault of this type would present security concerns for the Department. Given that the Department and providers both possess PHI, establishing such an exchange where all providers had access would present a security challenge. The Department often requires updated information yearly or more often. Simply uploading data and then not updating it on a regular basis would not allow the Department to comply with its verification requirements. Additionally, there is some indication that the new MMIS system will help reduce unnecessary duplication.</p>

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	<p>human services Department have access to the vault. Service providers must register to receive authorization to use the system by visiting a designated state website.</p> <ul style="list-style-type: none"> • The vault accepts and securely stores data using an easy-to-use web form to make entries and upload documents for review by state agencies. • Relevant data and documents from human service providers are collected at once and shared among these agencies, relieving providers of the administrative burden of repetitive requests for similar information. 	
	<p>Administrative burdens on providers and vendors</p> <p>Recommendation: Deemed Status There should be a <i>Deemed Committee</i> to address Deemed Status, an effort to “deem” certain licensing standards when an Department is accepted. Accreditation standards can be “cross walked” to certain state Department rules. Policy and legal personnel must review any rule changes and develop policy guides/procedures for how deemed status would be consistently applied. Private sector members of the committee should provide input into those policy guides.</p> <p>Members of the <i>Deemed Committee</i> should monitor the outcome of the deemed status process during license renewals. The committee must determine whether there is merit to the time investment needed to review crosswalks for CARF and JCAHO, as most may be accredited by COA.</p>	<p>SCDHHS will explore the feasibility of creating a deemed committee, as described in the burden. State and Federal requirements will be reviewed as part of the feasibility study.</p>
	<p>Model BOI after what midwives are doing.</p>	<p>This recommendation will be reviewed and taken under advisement.</p>
	<p>Natural birth saves money.</p>	<p>General comment. Will be considered.</p>
	<p>Department suffers in contracting out as customer service slips</p> <p>Recommendation: Acknowledge the concern</p>	<p>The Department understands the importance of reviewing regulations and will have systems in place to measure and improve its processes.</p>
	<p>No attention to ACA impact on providers</p>	<p>ACA impacts providers in many ways. Some of these impacts are outside the realm of SCDHHS. SCDHHS has created an internal team to identify all facets of the Affordable Care Act that impact Medicaid programs, or providers and our beneficiaries. Each item is identified and, if needed, a project is created to implement the provision. Providers are included in</p>

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		stakeholder input and receive communications by bulletins as well as other avenues when changes might impact them.
Hospice		
DHHS 149 Form, DHHS 151 form	<p>The whole hardcopy/paperwork-process regarding the Medicaid Hospice forms needs to be revamped. The Medicaid Hospice Benefit is supposed to “mirror” the Medicare Hospice Benefit, yet the process of Notice of Elections, Discharges, etc. is so much more cumbersome with Medicaid than with Medicare. Medicare allows each hospice to develop its own forms. For example, we have created our own Hospice Medicare Benefit Election Statement which would correspond to the DHHS 149 Form; we have our own Physician Certification/Recertification form which would correspond to the DHHS 151 form.</p> <p>Recommendation: To notify Medicare of a patient’s Hospice Medicare Election, we simply submit an electronic form, bill type 81A, for our Department. There are no hardcopy forms that we are required to send to Medicare. They are simply part of the patient’s medical record/chart. The Medicaid Hospice Benefit should follow suit – so that it truly “mirrors” the Medicare Benefit. Surely, the SCDHHS Web Tool could be modified to accommodate and accept an electronic version of the Election form. If a patient is “Medicaid-only”, i.e. not Medicare/Medicaid-dual, the process is even worse as everything has to go through KEPRO; there is even more paperwork – and again, it’s all hardcopy.</p>	Staff is currently reviewing all SCDHHS Medicaid Hospice forms and policy to better align current processes with Medicare's. Staff will continue to work with association leadership and providers to seek input.
	<p>The South Carolina Home Care & Hospice Association, a 34-year old association representing home health, hospice, and personal care/private duty home care agencies across the state, appreciates the opportunity to comment on existing regulations. Our home care agencies that provide services under the Community Long Term Care Waivers have outlined the following areas for your consideration. There is an unwritten policy in place that home care aide staff members using the Care Call system are allotted 6 “strikes.” Many of these strikes are for issues that are beyond the control of the staff and Department. One example is when Department staff members are not able to check-in at the client’s home because the client does not have a functioning phone, and the case manager is not notified within 48 hours of the service event. The resolution procedure for these strikes is implemented inconsistently across case managers. In some cases, clients have not had functioning phone for long periods of time, yet strikes are assigned for lack of notification. We believe that the “strike” practice of not submitting for claim, what would otherwise be a valid service provision, is not appropriate.</p> <p>Recommendation: We request that procedures be clarified and standardized, including the definition of a “strike” and how issues can be resolved or eliminated.</p>	CLTC is in the process of developing an alternative solution for aides to document service delivery to recipients who do not have a land line phone. During the upcoming summer and fall provider meetings, clarification will be provided as to the definition of a strike and when a strike will be assessed. CLTC will also provide training to staff to ensure the policies are being provided consistently, and providers will be asked to promptly notify CLTC of inconsistencies.

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	<p>Another area of concern is the requirement for having to conduct aide supervisory visits on admission, again within 30 days, and then every 4 months. Additionally, supervisory visits are required after client hospital stays. This requirement is more strenuous than found in many other states. The requirement for supervisory visits within the first 30 days is especially problematic for agencies.</p> <p>Recommendation: We request that SCDHHS reflect on this requirement to see if there is an opportunity for flexibility in the frequencies for these visits, allowing administrative staff to conduct the visits, or allowing some supervision to be conducted as a phone call with the client. As a reminder, the Nurse Supervisors provide no hands on care and are not providing skilled home health services.</p>	<p>The nurse supervisory visit requirement has been substantially changed over the years. At one point, providers had to make on-site visits every other month instead of every month. SCDHHS will continue to review this policy. However, any changes that reduced the frequency of nurse supervision visits must be made with consideration of the safety and welfare of frail elderly and persons with disabilities living in their homes.</p>
	<p>Hospice/Facility Room and Board Pass Through: Process is cumbersome for both provider groups and there is high risk for error by both provider groups. The hospice maintains the bulk of the financial risk if rates are miscalculated and adjustment in reimbursement is necessary. While there has been some report by nursing facilities regarding timely payment of the R&B rate by the hospice, hospices have also had difficulty recouping any overpayment they may have made to the nursing facility.</p> <p>Recommendation: We recognize this is a CMS requirement and only one or two other states are not utilizing the R&B pass through payment process. Would it possible to seek a waiver of this from CMS? In addition to the burden on providers, this continues to be an administrative challenge for DHHS. With the apparent dissolution of specific program area staff positions, this will become an more difficult process for providers and the burden of questions and resolution will fall to the Customer Service Center and staff there do not appear to be sufficiently prepared to assist providers in navigating and resolving the issues that arise from this process.</p>	<p>Staff is currently making revisions to claims submission policies and procedures. A team has met to discuss reverting back to electronic claims submission for all Hospice/Nursing Facility room and board claims (T2046). This will expedite payment. SCDHHS will also work with Medicaid Program Integrity on post payment reviews. Staff consulted with CMS and was informed that payment for Hospice/Nursing Facility room and board claims must be "passed through" the Hospice to the Nursing Facility.</p>

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	<p>CLTC/Hospice Overlap</p> <ul style="list-style-type: none"> Current structure of hospice/CLTC program overlap creates an inherent deterrent/limit to access of hospice to Medicaid beneficiaries. For example, a patient receiving a number of hours per day of in-home, non-skilled support through CLTC cannot elect hospice without giving up that service. Patients and families are most often reluctant to give up a service/provider they are comfortable with even if hospice provides them with a wider array of services. This is certainly a burden to patients and families that would otherwise desire and benefit from election of hospice services. It creates a burden for hospice providers that may expend time and resources preparing for admitting patients that are then identified as receiving these services and thereby not eligible to elect hospice. This is also a financial burden to the state as the more folks enrolled in hospice, the more efficiently healthcare dollars are expended. <p>Recommendation: Look at other states to see how they have implemented their community based waiver programs such that they are compliant with CMS requirements to avoid “double-dipping” and limiting the negative impact of the program’s structure. Work with the hospice and CLTC providers to implement any changes that may be allowed by CMS.</p>	<p>Hospice benefit is a prescribed package which includes physician services, nursing, medical social work, respite, bereavement counseling, inpatient care, medical supplies, home health aide and homemaker services, PT, OT and ST. Hospice recipients who are enrolled in a HCBS waiver may receive services from both programs; however, services cannot be duplicative. These services must not duplicate services as stated in the hospice plan of care, as specified in the 42 CFR 418.00. Bulletin link: https://www.scdhhs.gov/internet/pdf/Home%20Health%20&%20Hospice%20Providers%20.pdf</p>
General Medicaid Policies/Procedures	<ul style="list-style-type: none"> Medicaid has created a required set of documents (election, certification, discharge, revocation, etc. forms) that contain the same required information as the hospice agencies’ own forms which are required to meet strict guidelines set forth by CMS for Medicare hospice beneficiaries. While Medicaid hospice patients are typically a very small percentage (less than 5%) of the total patients, having to complete and submit separate reports is a burden for providers. There are also timeliness of submission requirements for Medicaid hospice beneficiaries that vary slightly from those same requirements for Medicare hospice patients. This creates an undue burden on providers’ internal processes and can result in errors that can result in delay in start of care, result in payment delays/error. This requires dually-eligible patients to sign two sets of forms for the same care which creates a burden for them at a very vulnerable and stressful time. <p>Recommendation: DHHS work with the hospice industry to evaluate the processes and forms in the current Hospice Provider Manual and revise accordingly to eliminate burdens to patients/families, hospice providers and the state.</p>	<p>Staff is currently reviewing all SCDHHS Medicaid Hospice forms and policy to better align current processes with Medicare's. Staff will continue to work with association leadership and providers to seek input. Staff is examining online submission.</p>
	<p>3rd party to approve hospice. Provider service center is not helpful.</p> <p>Recommendation: Would like provider representative for escalation.</p>	<p>SCDHHS is meeting regularly with Provider Service Center (PSC) management and staff to identify training opportunities for PSC staff. Staff continues to update policy manuals and revise training tools.</p>

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	<p>Hospice patients have to choose between CLTC and hospice. Want to help patient to stay at home, but end up choosing CLTC and don't get hospice benefit.</p> <p>Recommendation: Combine resources from CLTC and hospice (can do for under 21)</p>	<p>Hospice benefit is a prescribed package which includes physician services, nursing, medical social work, respite, bereavement counseling, inpatient care, medical supplies, home health aide and homemaker services, PT, OT and ST. Hospice recipients who are enrolled in a HCBS waiver may receive services from both programs, however, services cannot be duplicative. These services must not duplicate services as stated in the hospice plan of care, as specified in the 42 CFR 418.00. Bulletin link: https://www.scdhhs.gov/internet/pdf/Home%20Health%20&%20Hospice%20Providers%20.pdf</p>
	<p>Frugal treatment during vegetative state. Provider needs to educate on options.</p> <p>Recommendation: Require providers to educate about choices, compensation</p>	<p>SCDHHS will meet with providers and associations to address the concern. Staff will also conduct preliminary research.</p>
Managed Care		
MCO requirements for Substance Abuse	<p>The new MCO prior authorization process has also added a tremendous burden to our Department in terms of administrative work required in delivery of services to our clients. This process requires more staff hours devoted to obtaining this prior authorization and yet the turnaround time for reimbursement is much slower.</p> <p>Recommendation: Remove the requirement for PA on Outpatient Services</p>	<p>Originally under FFS, outpatient services for Substance Abuse did not require Prior Authorization. Now under the MCO model, Providers are required to get a PA for Outpatient Services.</p>
	<p>Currently, Medicaid recipients in Managed Care areas are seeing any provider they wish to, contrary to the policy behind Medical Homes and Coordination of Care. Further, these Medicaid recipients do not have photo identification and are often not tasked with providing any identification when they receive services. This adds to fraud and abuse, but we don't know the extent of this problem as Program Integrity has no oversight of Managed Care because the contract language was not drafted to address the MCOs' regulatory and procedural oversight and fraud/abuse prevention.</p> <p>Recommendation: Have DHHS attorneys draft tight contract language giving Program Integrity, with its infrastructure and expertise, the ability to oversee and implement corrective actions where</p>	<p>The Department has recognized these issues. Currently drafting contract language that would give PI more authority over going after fraud waste and abuse if identified and MCO does not have an open case. The Department would recoup all that money for the Department.</p>

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	MCOs are deficient and/or ineffectual in managing Medicaid funds paid to them.	
	<p>Comments from providers on the enrollment and prior authorization of MH providers and services. In addition, each Managed Care company must also individually credential and approve LIPs and/or therapist. Also different referral and authorization forms.</p> <p>Recommendation: One mandatory referral form; common referral processes; common credentialing criteria no matter the MCO or payment source</p>	SCDHHS staff (LTC/BH and Managed Care) are currently in the process of examining the credentialing procedures.
	<p>HMO Medicaid has not been explained nor is there a source for clear explanation for participants, nurses and nursing homes. The agreement made in good faith by those in Columbia with the HMOs is not what is in practice in reality. As a result, participants are assessed and suddenly in the process they are in an HMO. If referred to the HMO, those employees have no idea what Community Choices is and participants are told there is no "regular Medicaid." Participants have to disenroll from HMO and it is impossible to have them informed about the advantages or disadvantages if the nurses do not have an adequate referral source. Also, there are no nursing homes who will take a participant with HMO Medicaid. I have been told that there has been payment for only 6 days of rehab, paperwork is overwhelming, and payment for stays takes 6 months to a year to reach the nursing home. This means a backlog for the hospital, which results in an expensive Medicaid bed, a participant inappropriately remaining in hospital, or a discharge that is not ideal.</p> <p>Recommendation: Have a meeting with the HMO representatives present and a representative from each CLTC office present, possibly on a small, local scale and have contact person at the HMO plus paperwork that has hard facts we can count on. Thank you.</p>	SCDHHS is currently working on provider and consumer training and education resources regarding HMO/MCOs and Nursing Facilities.
1932(b)7 SSA	<p>1932(b)7 of the SSA With eliminate of Medical Homes Network, unable to contract with MCOs.</p> <p>Recommendation: Would like to bill under FFS or carve-in to MCO</p>	SCDHHS covers Birthing Centers in our FFS program. Managed Care must provide at a minimum the same level of service.
	<p>MCO programs required different billing codes.</p> <p>Recommendation: Unified billing codes</p>	All MCOs follow the correct coding initiative and have flexibility for how they use these codes in their policies. Will take this recommendation under advisement.
Medicaid Managed Care Retro-enrollment	Require Medicaid managed care plans to apply timely filing to cases involving retroactive coverage resulting in expensive appeals and denials. SC DHHS has not mandated a process for the managed care plans to properly process coverage for those members who are approved retroactively and choose participation in an HMO plan (specifically, moms, newborns and babies). Therefore, many times retro-coverage is granted and an HMO is selected yet the affected visits are outside of the timely contractual for the managed care plan as they do not follow the traditional Medicaid timely	The Medicaid system doesn't provide a Medicaid number until a person is "born" (i.e., newborn). Initially the baby is part of FFS Medicaid - while in hospital (e.g., 90-days). Once determined the Mother is with Plan-X

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	<p>limit. As a result, these retro claims are denied and then must be appealed to be reconsidered. This is unnecessary costs for both the provider and the state in both money and time. SC hospitals currently serve prospective Medicaid clients before they have submitted an application to the Medicaid program or during the span when their application is in pending status. These patients are expectant mothers, neonates and children. We treat them regardless of their ability to pay or the status of their application. This segment of our SC population is often the most critically in need of care and assistance to insure healthy starts for South Carolina's youngest and most precious resource. However, when retroactive coverage is deemed appropriate, their selection of a managed care plan could mean their retroactively covered visits will not be processed. Managed care companies are hiding behind contractual timely filing guidelines instead of reimbursing for these visits. The hospital is told the only recourse is to accept the denial and then appeal the claims to receive reimbursement.</p>	<p>(HMO), SCDHHS retro-enrolls the baby with the Mother's Plan. SCDHHS pulls back the original FFS payment from the provider and facility once the baby is retro-assigned to an MCO. Medicaid FFS normally takes its money back from the hospital after the first 90 days. Some MCOs contractually (BlueChoice) only allow new claims (under contract with providers) to be filed within 90 days of the date of service. Contractually, SCDHHS is exploring possible solutions in the new FY 14 contract with the MCOs that may alleviate the timely filing barrier for funds and claims to be resolved.</p>
	<p>Problem: Licensed Midwives are unable to be authorized providers in MCOs as the practice partner agreements currently exist. The DHHS decision to eliminate the Medical Homes Networks (MHNs) by the end of the year will effectively eliminate Licensed Midwives as a provider option to eligible women.</p> <ul style="list-style-type: none"> • In the SC DHHS Provider Manual, Updated 4/1/2013, Licensed Midwives are referenced in Section 2, Page 4, and have been eligible providers since 1994. • Section 1932(b)(7) of the Social Security Act reads: “(7) Antidiscrimination.—A Medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification. Therefore, the MCOs in South Carolina are in violation of the federal SSA statute by disallowing LMs from being authorized providers within their structures. • When women are initially deemed eligible for Optional Coverage For Women And Infants, they are initially covered under the Fee-For Service option for the first **30** days. After this time, women are forced to choose an MCO or MHN, or will be randomly assigned to one. • Without the Medicaid income from women who have opted for a MHN, specifically SC Solutions, the potential closure of several of the 5 LM-owned and operated birth centers is very real. This would affect over a dozen LMs who currently attend deliveries in birth centers, and the LMs who accept Medicaid for home birth. • LMs have enjoyed ease of billing and reimbursement with the FFS option. 	<p>There are two classes of midwives in the state certified and licensed. The licensed midwives are individuals that are not a medical or nursing professional but are licensed by DHEC. These currently aren't recognized by the MCO's. They do recognize and credential the certified nurse midwives.</p>

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	<p>Recommendation: Maintain the Fee-for-Service Option for all women who opt to receive care from Licensed Midwives. Do not force a woman who has chosen to begin her prenatal care with an LM to select an MCO. If a woman decides to switch to a Licensed Midwife after the onset of care with any other provider, grant her rapid transition to the FFS option so no lapse in prenatal care occurs.</p>	
	<p>Do not know when new MCOs come into area.</p> <p>Recommendation: MCO updates should be posted on the website and sent out via bulletin notification</p>	<p>For Medicaid Managed Care, bulletins and public notices are sent. For all MCOs, marketing materials (consumer and provider) must first be approved by SCDHHS before the MCOs can distribute.</p>
	<p>Was told FFS would never go away. Moms are burdened by choosing</p> <p>Recommendation: Keep FFS. It is simple and straightforward.</p>	<p>FFS has demonstrably poorer results than managed care at higher cost, which is why the Department continues to move toward managed care.</p>
<p>MCO Contract 1.4 12.4</p>	<p>The South Carolina Department of Health and Human Services (the Department) has consistently informed the Health Plans (the Plans) that MCO policy and procedure will be relayed to the Plans either through the two guiding documents - the MCO Contract and the MCO Policy & Procedure Guide - or by way of a Medicaid Bulletin. The Plans were instructed to rely solely on those three documents for guidance on MCO policy and procedure. While the Department does use these means of relaying policy and procedure, the Department also relays changes to policy and procedure through letter, email and/or comments made in meetings, and with no formal follow-up to substantiate the change. This creates a conflict between the Department's new expectations and the current policy and procedure as outlined in the guiding documents. This also leads to lack of clarity on the part of the Plans as to how to proceed and necessitates constant requests to the Department for clarification, which is rarely provided through the proper methods outlined above. This method of notification often puts the Plans in the position of having little if any time to make the administrative and system changes necessary to implement the change, resulting in undue and unnecessary administrative burden on the Plans.</p> <p>Recommendation: The Department should follow its established procedure of providing notification to the Plans of changes to policy and procedure only through the official channels - the MCO Contract, the Policy and Procedure Guide and/or a Medicaid Bulletin.</p> <p>The Department should also provide sufficient notice of upcoming change to Policy and Procedure so the Plans have sufficient time to provide input and make any administrative and system changes</p>	<p>The Department will meet with plans to further streamline communication of changes to policy and procedure,</p>

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	necessary to implement the change.	
MCO Contract 3.6.”	<p>This policy potentially penalizes the Plans for changes required by the Department or for federally required changes.</p> <p>Recommendation: We recommend that the Department change this Section to read: "The Contractor shall be charged for any Plan initiated changes to its network, website, mailings, Contractor specific services or any other change that requires any alteration or modification of the Department's information provided to Medicaid MCO Members or Providers related to this Contract. For Plan initiated changes, the Department will provide the Plan an estimate of the required change. Any cost over and above the estimate must be approved by the Plan prior to the work being concluded."</p>	<p>CMS requires SCDHHS to seek approval for all contracts (Section 1 of contract/P&P). It is assumed that the interpretation is that SCDHHS is initiating the required change. The section reads (implies) a change initiated by the contractor. Therefore, this suggestion is not applicable. The Department will explore enhancements to terminology used in these sections (e.g., syntax).</p>
MCO Contract 13.45 P&P Guide 13.0	<p>Federal regulations require state Medicaid agencies to verify that each Medicaid provider has not been excluded from participating in federal health care programs.</p> <p>The Department has delegated this responsibility to the Plans. As a result, since the great majority of providers are enrolled in most if not all of the MCO networks, each of the Plans ends up checking the same providers against the federal and state exclusion databases each month.</p> <p>Recommendation: The Department should move vigorously toward developing a centralized in-house regulatory-compliant process to periodically check all participating providers against state and federal exclusion databases. This would eliminate the administrative burden and costly duplication of effort imposed upon the providers and Plans by the current process.</p> <p>Alternatively, the Plans should be permitted to utilize the Department's exclusion checks for any Medicaid participating provider that is in the Plan's network.</p>	<p>Regarding credentialing --Today, all MCOs perform all credentialing procedures. Providers must adhere to individual MCO requirements. The purpose of this section is to ensure Providers are in compliance and fully credentialed to provide services. While SCDHHS agrees with the comment about the level of effort required to perform this task, the beneficiary's health and safety are paramount and credentialing service providers helps ensure quality. Similar to 13.0, quality assurance is paramount to patient safety and health.</p>
MCO Contract 4.9	<p>This provision discourages innovation in delivery of care and places the Plans at an unknown risk since there is no requirement for estimate and approval of additional costs.</p> <p>Recommendation: We recommend that the Department add the following to the end of the first paragraph in Section 4.9: "For Plan initiated changes, the Department will provide the Plan an estimate of the cost involved. Any cost over and above the estimate must be approved by the Plan prior to the work being concluded."</p>	<p>This section of the MCO contract is referring to material changes to various types of resources that contain this information and share it with the public (e.g., print, web, other). If an MCO introduces a change using the examples given by the submitter, there is an impact to other parties involved (e.g. Enrollment Broker, SCDHHS). All these impacts must be</p>

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		communicated to these parties in order to plan, prepare and execute the requested changes. It is important to recognize that all parties involved will experience an impact from a change requirement from the MCO (e.g., time and costs). Generating a cost estimate adds an additional level of burden of effort from all parties creating additional costs and work.
MCO Contract 4.12.2	<p>There are circumstances in which a Plan could lose a vital provider in a geographic area resulting in network inadequacy. In this event, the Plan may be required to decertify that county until it can resolve the inadequacy. Having to terminate all existing Provider contracts within the county makes the recertification process inordinately difficult and imposes significant burden on the provider community.</p> <p>Recommendation: We recommend that this requirement be deleted as it serves no constructive purpose.</p>	The Department will discuss as part of the changes to the 2014 contract.
MCO Contract 4.12.2	<p>In this scenario, the Plan's network has already been approved by the Department. Therefore, if there is no material change to the Plan's network then there is no legitimate basis for terminating the county in question.</p> <p>Recommendation: We recommend that the phrase "whether or not a material change in the Contractor's network has occurred" be deleted from this paragraph.</p>	The Department will discuss as part of the changes to the 2014 contract.
MCO Contract 4.12.2	<p>The Plans currently provide the Department with a listing of network providers each month from which the Department can determine any additions and deletions from the network.</p> <p>This new requirement would have the Plans obtain preapproval by the Department for any increase or decrease in the provider network regardless of its impact on network adequacy. This is not the way network development functions as Providers are added and deleted every day.</p> <p>This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to potentially subject the Plans to punitive action on the part of the Department.</p> <p>Recommendation: We recommend that the words "are not prior approved by the Department and/or" be deleted from this section.</p>	The Department will discuss as part of the changes to the 2014 contract.

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MCO Contract 7	<p>This language is inaccurate as the Plans are allowed to market to Medicaid-eligible individuals as governed by subsequent guidance on marketing requirements outlined in the MCO Contract. Therefore, this sentence is in direct conflict with the subsequent guidance.</p> <p>Recommendation: We recommend that this sentence be deleted from Section 7 of the MCO Contract.</p>	The Department will discuss as part of the changes to the 2014 contract.
MCO Contract 7.1, 8.3.1, 8.4 P&P Guide 14.3	<p>This is one of several instances of conflicting information in the guiding documents provided by the state that impose the burden on the Plans to continually seek clarification, which impedes the proper administration of the Medicaid MCO program.</p> <p>Recommendation: We recommend that the references in the MCO Contract be changed to indicate member materials should be written at no higher than a seventh grade level to be consistent with the P&P Guide.</p>	The Department will discuss as part of the changes to the 2014 contract.
MCO Contract 9 - Grievance and Appeals Procedures: 9.1.2.1.2 9.1.2.2.1	<p>The first section (9.1.2.1.2) matches verbatim the federal language at 42 CFR 438.402(b)(ii). The second section (9.1.2.2.1) conflicts with the first and therefore conflicts with the Code of Federal Regulations.</p> <p>In response to a request from the Plans for clarification, the state responded that the member's written consent will not be required from the member's physician, and utilizing it against current contract language could result in sanctions to the Plan.</p> <p>This conflicting guidance poses significant risk for the Plans in that compliance with 9.1.2.1.2 as written puts the Plans at risk for sanction by the state, whereas compliance with 9.1.2.2.1 puts the Plans out of compliance with federal regulations.</p> <p>Recommendation: We recommend that the Department resolve this conflict by deleting from 9.1.2.2.1 the sentence that says, " During the Contractor's Appeal process neither the Medicaid MCO Member nor the Provider who is acting on behalf of the Medicaid MCO Member is required to provide a written authorization."</p>	SCDHHS understands that providers have procedures and forms in place that allow the provider to act on behalf of the Medicaid Member. Forms that allow the provider to file claims to any insurer, forms that allow the provider to share HIPAA related information, etc. 9.1.2.2.1 is stating that we don't expect the member to sign additional forms beyond what the provider has already gotten to the member to sign upon first being seen. This additional section is attempting to reduce the administrative burden for the provider when a dispute with the MCO ensues. The CY2014 MCO Contract will allow the Provider Forms (signed by the Medicaid Member) to serve as the approval (authority) document/record.
MCO Contract 10.16	<p>This is a tremendous waste of time and effort for the Plans and the Department that provides no programmatic benefit. If the Department has approved a document and the document has not changed in any way, there is no purpose served by submitting it to the Department each year.</p> <p>Additionally, every plan undergoes an annual External Quality Review process in which every one of</p>	It is assumed that the comment is referencing Member Handbooks, P&P's, etc. If this assumption is correct, the purpose of this section is to allow SCDHHS to review MCO

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	<p>the Required Submissions documents is reviewed for compliance with state policy and procedure. Therefore, it seems unnecessary and excessive to require the Plans to send the same documents to the Department each year for no apparent purpose.</p> <p>Recommendation: We recommend that the Department delete this requirement and rely on the External Quality Review process to conduct the document review that it is designed and intended to provide.</p>	<p>P&P's. If an MCO submits a policy/procedure (individual) that impacts other policies within and outside of a section, SCDHHS needs to understand the impact (scale and scope) in real time in order to react and respond in the best interest of the Medicaid Beneficiary and Department. The concern is that an individual policy change could negatively impact a provider, member or service without SCDHHS knowledge. As such, these changes need to be communicated to all parties involved (i.e., SCDHHS) to ensure operational efficiencies and transparency.</p>
<p>MCO Contract 11.4</p> <p>P&P Guide Appendix 6</p>	<p>11.4 Auto-Assignment Algorithm: "The Department shall update the managed care auto-assignment algorithm to direct beneficiaries to managed care health Plans that have higher quality and performance measures, as reasonably determined by the Department or its designee."</p> <p>P&P Guide Appendix 6 - Quality Weighted Auto Assignments: "New health Plans will receive member assignments based on the Quality Weighted Assignment Factor for a three star health Plan. Once the new health Plan receives a rating, assignments will be based on that value at the start of the next period."</p> <p>Recommendation: We recommend that the provision in Appendix 6 be changed to state that members are assigned to a new Plan based upon the baseline "two star" assignment factor, thereby eliminating the unfair advantage created by the current arbitrary "three star" assignment factor.</p>	<p>The 3-star threshold has been set by SCDHHS to ensure quality health outcomes.</p>
<p>MCO Contract 12.7</p>	<p>"Provider manuals" was added to this section of the MCO Contract without notice to the Plans. The Department has always defined Marketing as "Any communication approved by SCDHHS from an MCO to an existing or potential Medicaid Recipient that can be interpreted as intended to influence the Recipient to enroll in that particular MCO Medicaid product..."</p> <p>The provider manual is not a tool for marketing to potential or existing member and therefore is not considered a Marketing Material and, per the Department's definition of Marketing, should not be</p>	<p>If the "Designee" (the agent of the principal) utilizes and/or references the information contained within a provider manual for the purpose of establishing contracts with providers, this may be considered marketing for contracting purposes with providers.</p>

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	<p>subject to review.</p> <p>When we asked the Department if it was changing its definitions of Marketing and Marketing Materials, the response was that they are not changing the definition of marketing materials but simply expanding their requirements for review to include provider and other materials.</p> <p>This is a perfunctory change made by the Department without consideration of the administrative burden it imposed on the Plans. It is also another example of the Department's failure to follow its procedures to properly notify the Plans of policy changes.</p> <p>Recommendation: We recommend that the reference to "provider manuals" be deleted from this section.</p>	<p>If the comment is referencing BlueChoice's provider manual, the information must be reviewed to ensure compliance.</p>
MCO Contract 13.2.9.18	<p>The Contractor (Plan) has no control over who is performing the work and at what price but yet is held financially responsible for the costs involved.</p> <p>Recommendation: We recommend that this section be deleted or at least changed to stipulate that the Contractor will be apprised of the costs associated with the termination and allowed to determine that the costs being incurred are reasonable and equitable.</p>	<p>The Department will discuss as part of the changes to the 2014 contract.</p>
MCO Contract 13.3	<p>This section relates to the process in which incentives are paid to the Plan for meeting performance goals and the Plan then passes on a portion to the appropriate provider(s).</p> <p>There are two arguments against requiring the Plan, even a terminating one, to refund incentive money: First, an incentive is earned based upon past performance. Therefore, there is no justification for requiring earned payment to be returned. Second, by extension if the Plan has passed part of its incentive payment on to a provider in a manner prescribed by the Department, there is no justification for requiring that portion of its earned payment to be returned either.</p> <p>This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to subject the Plans to punitive action by the Department.</p> <p>Recommendation: We recommend that the second paragraph of this section be deleted.</p>	<p>The Department will discuss as part of the changes to the 2014 contract.</p>
MCO Contract 13.4."	<p>In the event of an appeal decision being overturned in favor of the Plan, it is neither reasonable nor equitable for the Department to charge the Plan for costs the Department incurs in the unsuccessful defense of its own action.</p> <p>This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to subject the Plans to punitive action by the Department.</p>	<p>The Department will discuss as part of the changes to the 2014 contract.</p>

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	<p>Recommendation: We recommend that the phrase "less any cost incurred by the Department" be deleted from this paragraph.</p>	
P&P Guide 2.6	<p>We would note that Section 2.7 - New Boilerplate Subcontract says, "Article I encompasses all SCDHHS required language." This reflects the fact that the Department developed standardized contract language that must appear as Article I in every provider contract to ensure that each contract addresses mandatory federal and state requirements. Ensuring the presence of this language also relieves the state from having to review every provider contract for every Plan to ensure those requirements are addressed.</p> <p>The Plans were informed that once Article 1 was in all provider contracts, the Plans were free to modify the remaining terms of the contract to fit their needs and did not have to send new or revised the contracts to the state for review and approval. It is our belief that Section 2.6 contains language that is outdated and obsolete now that the Plans have included Article I in all provider contracts.</p> <p>Recommendation: We recommend that the Department revise this Section by deleting the obsolete language.</p>	<p>SCDHHS is currently aware of provider contracts that do not have Article 1 currently. There are MCOs that are now not using the updated boilerplate and did not follow through with their plans to update their boilerplates. This is why the language is structured in the P&P in this manner. SCDHHS is looking at ways to restructure this language, but the requirements will remain that we will need to see any contract that is not on the new boilerplate because article I sets out all the Medicaid requirements and in older contracts the Medicaid requirements are imbedded throughout the entire contract between the MCO and Provider.</p>
P&P Guide 2.9	<p>First, we would refer to our comments related to Section 2.6 above and the fact that the presence of Article I in provider contracts relieved the Plans from having to submit any revisions to the balance of the contract to the Department for review.</p> <p>Second, we would note that Section 8.0 of the P&P Guide says, "The relationship between the MCO and the provider is governed entirely by the contract between the parties. In this contract the provider agrees to accept Medicaid Members and the MCO agrees to pay for the provision of services as outlined in the contract. Thus, the issue of payment to the provider by the MCO is an issue between the two parties. SCDHHS is not a party to this agreement and will not exercise its authority to enforce the provisions of the contract between the MCO and the provider."</p> <p>Since the Department took steps to relieve itself and the Plans from the administrative burden of state review of amendments to provider contracts, and since the Department states it will neither review nor enforce the provisions of the Plans' contracts with providers, it is difficult to understand why the Department would choose to include new language that recreates the very administrative burdens it sought to eliminate in the first place.</p>	<p>SCDHHS is currently aware of provider contracts that do not have Article 1 currently. There are MCOs that are now not using the updated boilerplate and did not follow through with their plans to update their boilerplates. This is why the language is structured in the P&P in this manner. SCDHHS is looking at ways to restructure this language, but the requirements will remain that we will need to see any contract that is not on the new boilerplate because article I sets out all the Medicaid requirements and in older contracts the Medicaid requirements are imbedded throughout</p>

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	<p>Recommendation: We recommend that the Department revise this Section by deleting the second paragraph.</p>	<p>the entire contract between the MCO and Provider.</p>
<p>P&P Guide 4.2</p>	<p>Previous versions of the P&P Guide state that for Providers who serve both the commercial and Medicaid populations, an identifiable separate page of the Credentialing Committee minutes that separately addresses each Medicaid provider being considered is acceptable documentation of the Medicaid Credentialing process.</p> <p>These new guidelines are excessive and administratively burdensome. We would also note that all Plans are now required to be accredited by NCQA, a process that includes stringent Credentialing requirements. Therefore, the new guidelines are unnecessary and do nothing to enhance the Credentialing process.</p> <p>This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to subject the Plans to punitive action by the Department.</p> <p>Recommendation: We recommend that the Department retract these requirements and reinstate the previous guidance.</p>	<p>This policy is in place to ensure that MCOs do not blend their commercial product lines with their Medicaid processes and programs. In the past MCOs have used commercial contracting with providers to indicate their network adequacy under Medicaid. This process ensures that all parties, providers/SCDHHS and MCO are all aware of who is a truly contracted and providing service to the Medicaid population at large. Before policy implementation providers were unaware of their contracting with both the Medicaid and Commercial lines of the MCOs product line. When Medicaid members went to a physician there was confusion regarding if they were truly contracted in the Medicaid MCO product leaving Medicaid members at risk.</p>
<p>P&P Guide 4.2</p>	<p>42 CFR455.104 (c) says Medicaid agencies must require providers to provide disclosures of ownership: 1) at application/execution of the agreement; 2) upon request of the Medicaid Department during the re-validation of enrollment process [at least every 5 years]; and 3) within 35 days after a change of ownership status.</p> <p>The Department has indicated that the disclosure of ownership is an integral part of the recredentialing process but we can find no regulation to that effect. Therefore, we believe the requirement to obtain disclosure of ownership at recredentialing (every three years) is an arbitrary schedule unsupported by federal regulation.</p> <p>Providers readily understand the need for disclosure of ownership at contracting (which occurs every 5 years) and at such time as their status may change, but they are resistant to what they see as an arbitrary periodicity of “every three years” when there is no apparent regulatory requirement. The</p>	<p>This is a federal requirement (CFR). MCO collection and verification of Ownership and Control Interest information. The Department’s position is as follows:</p> <ol style="list-style-type: none"> 1. SCDHHS agrees that the requirement that the “MCOs must verify the Subcontractor’s information at least yearly based on the date of execution of the contract (agreement)” means that the MCO must verify that the information is still current and

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	<p>process of obtaining disclosures of ownership more frequently than at contracting is regulatorily unwarranted and administratively burdensome for providers and Plans alike.</p> <p>Recommendation: We recommend that the Department revise its policy to state that Plans must obtain disclosures of ownership from providers at initial contracting and at least every 5 years thereafter during the recontracting process.</p>	<p>check for exclusions, terminations or loss of licensure.</p> <p>2. The MCOs are required to have all subcontractors fill out the DOO 1514 form prior to execution of the contract and/or submit a DOO 1514 within 35 days of any change of ownership and control interest.</p> <p>3. The disclosure of ownership and control interest information is an integral part of re-credentialing, not just a contractual requirement. The providers cannot be re-credentialed without this. So it should remain tied to re-credentialing schedule, which is every three years. This requirement will not change.</p> <p>4. Individual practitioners who are not incorporated or don't have "owners" per se still have to fill out the first part of the DOO 1514.</p> <p>5. Non-participating providers also have to be screened against the LEIE and EPLS when you enter into an agreement with them, even if it is for just one service or a limited time frame.</p> <p>6. Also, as SCDHHS moves to further incorporate ACA requirements into the Department processes, this will have implications for provider screening and enrollment on the managed care side. SCDHHS will be looking at ways to streamline this and avoid a situation where each plan plus SCDHHS is conducting multiple checks on the same provider. But right now there is</p>

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		no process for universal credentialing or even informal coordination in this area. Until we can construct such a new process, there may be further requirements incumbent upon the MCOs to screen their providers as well as providers' owners and other individuals disclosed on the DOO.
P&P Guide 16.0	<p>Federal regulations require state Medicaid agencies to obtain Disclosures of Ownership from Medicaid providers at application and periodically thereafter.</p> <p>The Department has delegated this responsibility to the Plans. As a result, each provider who participates with more than one Plan must provide a separate Disclosure of Ownership Form to each Plan it is contracted with. This creates unnecessarily burdensome duplication of effort for participating providers who serve the state's Medicaid population.</p> <p>Recommendation: The Department should move vigorously toward developing a centralized in-house regulatorily-compliant process to periodically obtain Disclosures of Ownership from all participating providers. This would eliminate the administrative burden and costly duplication of effort imposed upon the providers and Plans by the current process.</p>	<p>The Department is exploring this internally and will investigate ways of reducing the burden in this area. Ultimately review is required and agreement from various stakeholders is needed in order to change the current model operations.</p>

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<p>SCDHHS Physicians Provider Manual Section 2 - Alcohol and Drug Testing Policy</p>	<p>The Department's guidance indicates that G0431 is the proper code to use when providers bill for drug screening. However, the National Healthcare Common Procedure Coding System (HCPCS) has been revised to recognize G0434 as the proper code to use when providers bill for drug screening. This is recognition of the fact that very few professional providers possess the necessary equipment for the tests that would be properly reported using the G0431 code, and rarely is there a medical need for the type of testing indicated by G0431.</p> <p>The Department has failed to update its fee schedule to recognize this new coding. As a result, providers who bill for drug screening testing under the proper code of G0434 receive no reimbursement because that code does not appear on the state's fee schedule.</p> <p>The out-of-date fee schedule forces providers to billing using G0431 to get paid. Not only is this code inappropriate for the service provided, but it is also reimbursed at a rate that is significantly higher than the proper code of G0434, which improperly and unnecessarily increases the cost of service delivery for the Plans and the state.</p> <p>Additionally, the fact that the Department's failure to keep its fee schedule current forces providers to bill improperly to get paid subjects these providers to revenue recovery operations initiated by the Plans' Program Integrity units and to potential sanctions from federal agencies for the submission of false claims.</p> <p>Recommendation: We strongly recommend that the Department frequently monitor for changes to national coding standards on a regular periodic basis and promptly update its fee schedule accordingly. Alternatively, the Plans should be permitted to utilize the Department's exclusion checks for any Medicaid participating provider that is in the Plan's network.</p>	<p>The Department will examine this internally. SCDHHS is reviewing and updating the NCCI edits accordingly.</p>

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<p>R. 126-910 through 940; R. 114-1910 through 1930</p>	<p>DSS no longer administers the OSS program; DHHS has regulations, R. 126-910 through 940, governing OSS.</p> <p>Recommendation: SCDHHS should coordinate with DSS about regulations regarding the Optional State Supplement (OSS) program. DSS R.114-1910 through 1930, Establishing for Optional Supplementation, and other references contained in Chapter 114 should be repealed.</p>	<p>SCDHHS agrees South Carolina Code of Regulations Chapter 114 — Department of Social Services — Article 19 Establishing Eligibility for Optional Supplementation – sections 1910 – 1930 needs to be repealed. It is the regulation prior to South Carolina Code of Regulations Chapter 126 – Department of Health and Human Services – Article 9 Optional State Supplementation Program – sections 910 – 940, which was added by State Register Volume 24, Issue No. 3 effective March 23, 2001. However, DSS would be the more appropriate entity to seek deletion of its regulations.</p> <p>South Carolina Code of Regulations Chapter 126 – Department of Health and Human Services – Article 9 Optional State Supplementation Program – sections 910 – 940 was added by State Register Volume 24, Issue No. 3 effective March 23, 2001, needs to be updated to reflect the OSCAP changes. The South Carolina Department of Health and Human Services is currently drafting suggested changes to the above mentioned regulation in order to reflect the transformation from OSS to OSCAP.</p>

Policy

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	<p>Our Medicaid policies are often poorly written by non-attorneys and often not even health care providers so that egregious abuse occurs, and we have no leg to stand on to recoup the miss-spent funds. For example, providers were paid \$167.70 to perform an 80101 CPT code drug test that often amounted to an inexpensive qualitative drug test costing less than \$10.00-20.00, using their own office staff to perform such a test. Other expensive procedures, such as Supartz joint injections can apparently be performed by any physician, without prior authorization. This same cardiologist who performed 6-8 cardiac tests on each patient is now performing these joint injections, as his ability to order diagnostic tests in his office is limited. All these policies are in the Physicians Provider Manual, Section 2, see High-Cost Radiology Procedures requiring Pre-authorization, and Alcohol and Drug Testing Policies. As to Managed Care Organizations, we see the same abuse of high-cost radiologic testing and drug testing, with no apparent surveillance of the abuses that Program Integrity sees. MCOs are to be tasked with surveillance of fraud and abuse, are not noting and addressing these problems, and Program Integrity has NO statutory authority to monitor MCO misuse of services, nor ability to recoup overpayments. Further, the MCOs appear to have many internal problems requiring them to complete Action Plans to correct their deficiencies, and we want all Medicaid patients to enroll in these MCOS?</p> <p>Recommendation: Have health care providers, if not attorneys, to draft policies congruent with CMS regulations for Medicare, which seem to be workable. Begin placing limits on certain benefits that are prone to abuse, such as outpatient visits for adults and children, and ED visits. Where CMS regulations for Medicare are not workable for pediatric and obstetric patients, have attorneys and health care providers jointly draft appropriate, clear, cost-effective language to minimize ambiguities and "silent" areas in policy.</p>	<p>Complaints about Department policies and the burden they place on the Department are more appropriate for review in Phase II. There is no mention of a burden on providers relevant to Phase 1. Additionally, MCOs are largely governed by contract and contract language is currently being drafted to address the concerns expressed in the comment. Additionally, there are limitations on how much we can adopt from Medicare regulations and guidance due to the vast differences between the programs.</p>
	<p>There should be a universal web search for policy and procedures.</p> <p>Recommendation: There should be a concordance or a web search where I can type a statement or a word or a question, and it will direct me to a place in the Policy and Procedure Manual to assist me. The Policy and Procedure Manual helps in itself of course, but it should be much easier. Especially when you have a question and it takes a few minutes to locate the correct place in the manual. But if you have a place to type a question and it pops up telling you where you can find the answer that will help out even more.</p>	<p>It is possible to create a central repository of folders containing policies and then stand up a Google appliance back ended to Active Directory. It is possible to have natural language searches that present results based on assigned folder/group rights. This is an easy fix if determined a significant problem.</p>
Policy	<p>SCDHHS policy should not cause CNAs to lose their jobs, leaving health care employers to recruit, orient and train new employees if the CNA employee fails to renew their certification. SC policy should not cause CNAs continuing their education in nursing school to lose their nurse aide certification because they aren't working for money while attending college, but they are using their skills in the nursing classes and labs.</p>	<p>The Department will meet with the Nursing Home Association to further discuss.</p>

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	<p>Recommendation: Change SC nurse aide certification policy to minimize burden of costs to healthcare employers, college students, graduates of SC public high schools or graduates of state sponsored Family Independence or Workforce readiness classes/programs. A CNA who is working as a CNA or in Nursing School at the time of the expiration of his/her certification should not have to retrain or retest. Upon producing proof of employment or enrollment in nursing school, the requirement for retraining and retesting should be waived. However, the recertification fee or some such monetary penalty should be charged to the CNA for loss of certification. This is the policy of other states. Reason for policy update: The current SC Nurse Aide Program follows federal regulation when it requires CNAs to renew their certifications every two years. If a CNA fails to renew his/her certification, he/she loses the ability to work in a Medicaid certified nursing home by federal regulation or in any other health care setting where not Federal regulations nor SC law, but the SC employer's policies require current nurse aide certification such as in the industries of home health, hospitals, assisted living, etc. Upon loss of certification, the nurse aide must retest and possibly retrain via a state approved nurse aide training program (NATP) if the first NATP was not a state approved NATP at the time of his/her training. SC did not require test candidates to have completed state approved NATPs to be eligible to take the certification exam during the period 1989 – 2001. In some cases CNAs trained via SC taxpayer money in the form of public schools, SCDHHS sponsorship, Unemployment Workforce initiatives, or Family Assistance who do not renew their certification may need to be retested and retrained again using SC taxpayer money. Example: Rep. Jerry Govan's former nurse aide training program (NATP) in Orangeburg was not a state approved NATP until such time as it was required in order for graduates to test. A majority of high schools in the state did not have their NATPs state approved until it was required in order for graduates of the programs to take the nurse aide certification test. Each time one of these graduates who trained prior to the state approval of their NATP lets their certification expire, they lose their jobs and must retrain and retest possibly using SC taxpayer money again.</p>	
	<p>We have many forms in our program. More forms need to be added to the computer form section. For example, the incontinence forms.</p> <p>Recommendation: Enter all forms that are needed to follow policy.</p>	<p>SCDHHS is working to ensure that forms and manuals available on the website</p>
	<p>Freestanding Birth Center policies are under licensed midwife policies.</p> <p>Recommendation: Need separate policies as anyone can own a birth center.</p>	<p>Please refer to the Physician Services Manual. Each service is discussed separately.</p>
	<p>Recommendation: SCDHHS should promulgate regulations for the composition and role of the Medical Care Advisory Committee, including a provision for public participation at its meetings.</p>	<p>42 CFR 431.12 sets forth the composition and role of the MCAC. No specific provision in the federal regulations requires an opportunity for</p>

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		public participation at the MCAC meetings. The Department will end all future meetings with a public comment period.
	<p>Medicaid billing manual hasn't been updated recently. Have to search bulletins for updates that are not in manual</p> <p>Recommendation: Update manual timely</p>	Medicaid manuals are scheduled for updates the month following the effective date of policy.
	<p>Lack of communication on program changes</p> <p>Recommendation: Increase communication of changes</p>	The Communications Department will discuss with the MCAC ways to improve communication to providers and beneficiaries.
	<p>Need PCP to complete referral form for treatment. Requires beneficiary to make 2nd trip.</p> <p>Recommendation: Eliminate form</p>	Current policy states that a LIP (Licensed Independent Practitioner) has to receive a referral from a physician or state Department in order to provide therapy services. The referral process requires that the physician send the LIPS referral form to KePRO to authorize the initial assessment. KePRO sends the LIP an approval letter if referral is approved. After the LIP completes the assessment, the LIP must send the assessment to the physician who completes the MNS and sends to KePRO for authorization for further services. This is already being looked at for possible change to reduce hassle factors as well as to comply with Mental Health Parity Law.
	<p>Policy changes are only known when visiting website</p> <p>Recommendation: Push out information via listserv updates.</p>	Taken under advisement.
	<p>Manual references licensure requirements but does not link to them.</p> <p>Recommendation: Make clearer policies and include full details or licensure requirements instead of</p>	SCDHHS can only update and maintain its policies and procedures. Licensure requirements established by

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	linking or referring to another Department/source	LLR, DHEC, etc. are outside the Department's "ownership." The Department will work with LLR to determine how to best accomplish this.
	Policy needs to be written before implementing a program. I am processing expedited Foster Care cases and have very little guidelines for the program. A meeting is planned so I hope to give/receive input soon.	Policy and procedures were developed. This guidance will be added to the policy manual.
Procurement		
	<p>There are several policies - as expressed in provider contracts - that require providers to supply information that seems more related to controlling their organization than monitoring the provision of services, such as requiring the provider to provide organizational charts and bylaws, setting minimum hours of operation and minimum size and location of office space.</p> <p>Recommendation: I am not sure that we ever seek the information that we are "requiring" or that anyone ever actually reviews it. This language should be removed from the contracts and replaced with language that actually influences the quality of the services provided.</p>	The Department will review this issue internally.
	I receive many complaints related to the regulatory burden of the SC Procurement Code. These complaints are most often from internal sources rather than external sources.	No action required.
Provider Enrollment		
	<p>To enroll with Medicaid, must apply online with precepting physician.</p> <p>Recommendation: Precepting physician would be needed at time of claiming, but not required during enrollment.</p>	Medicaid needs assurance that a provider has met all of DHEC's requirements at the time of enrollment.
	<p>No ability to enroll as licensed midwife. Must enroll as a certified nurse midwife.</p> <p>Recommendation: Create category for licensed midwife.</p>	SCDHHS will explore the feasibility of creating a licensed nurse mid-wife category.
Provider Integrity		
Statute Section 1877 of the SSA, 42 U.S.C. Section 1395	Section 1877 of the Social Security Act, 42 U.S.C. Section 1395 et seq., also known as the Stark Law, prohibits physicians and other health care providers from self-referring to other owned entities providing Designated Health Services (DHS). These referrals are considered to create a conflict of interest where the provider benefits financially from self-referral. The "ancillary services exception" to Stark III vitiates Stark by allowing providers, commonly physician groups, to purchase expensive imaging and other diagnostic equipment and refer patients to have these tests, claiming medical necessity. One internal medicine group's cardiologist and his wife purchased a CT scanner, echocardiogram machine, nuclear stress testing, and other equipment and routinely ordered millions of dollars of testing on a large number of adult patients, often with no symptomatology, and a 95%	This comment will be taken under advisement.

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	<p>normal rate, but we recouped 38K. Second, our MMIS system is so antiquated, it is incapable of "editing" excessive use so that Medicaid patients can exceed their twelve visits easily, with those extra visits being paid. Other edits are not recognized, allowing other billings to be improperly paid. Further, we are unable to program the system with any enhancements that would "catch" billing errors before the money is paid. I have personally seen numerous patients receive 20-30 visits in one calendar year PLUS numerous ER visits when less expensive care was available.</p> <p>Recommendation: CMS and/or the Legislature should close the Ancillary Services Exception to high cost testing such as CT scanning, Nuclear stress and other testing, Echocardiography/other ultrasonography, high-cost Gas Chromatography and Mass Spectroscopy and other high-cost diagnostic testing. The pre-certification process should be rigorous, rather than a pro forma entry of CPT code, ICD-9 code, and brief patient history resulting in automatic authorization. MMIS needs to be overhauled substantially to place necessary edits and other forms of "logic" into place to prevent payments from being made contrary to established policy. This would require substantial capital expenditure as the system is too antiquated to handle the increased burden the increased Medicaid population imposes on South Carolina taxpayers.</p>	
Provider Requirements		
Private Rehabilitative Therapy and Audiological Services manual	<p>In the recent past, SCSHA board members met with HHS personnel regarding the timeline discrepancy across service providers with regards to completing and signing clinical service notes. Currently, speech-language pathologists in private practice follow the guidelines in the Private Rehabilitative Therapy and Audiological Services manual. The guidelines state that clinical service notes "must be made by the provider delivering the service and should be accurate, complete and recorded immediately." In a meeting with HHS personnel several years ago the "immediate completion" of clinical services notes was interpreted as completed and signed "the day of the service." Requests to change the timeline were not approved by HHS personnel.</p> <p>The "day of" completion and signing of clinical service notes for private providers practicing speech-language pathology is more strict and restrictive than for most other providers billing Medicaid under Private Rehabilitative Therapy services. A review of available provider manuals reveals variation in the requirements regarding clinical service notes across providers. Licensed Independent Practitioners Rehabilitative Service Providers, FQHC Behavioral Health Services Providers, and RHC Behavioral Health Services Providers are allowed up to 10 days to complete and file clinical service notes. Other provider manuals specify a caveat which states that "providers are to document immediately after the service but, if this is not possible due to the nature of the service ... have up to 10 days from the date of service." This caveat applies to Community Mental Health Providers, Local Education Department Providers and Rehabilitative Behavioral Health Services Providers (the latter are encouraged to complete clinical service notes immediately but are allowed up to 10 days). Lastly,</p>	The regulation allows for providers to submit a Hardship Waiver for review to SCDHHS. The waiver must be approved by CMS.

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	<p>Early Intervention Service Providers have a time period of “within 7 calendar days from the date the service is rendered” to complete clinical service notes.</p> <p>Recommendation: The South Carolina Speech, Language and Hearing Association respectfully requests that HHS review and consider a revision to the “immediate” and “day of” requirement for speech-language pathologists who are private therapy rehabilitative providers. The “immediate” and “day of” requirement currently places a tremendous burden on these providers. A degree of flexibility in the timeframe, as allowed for other providers, would greatly alleviate this burden. The board is open to meeting once again with HHS personnel to discuss options to this timeline.</p>	
Provider Service Center		
	<p>Call Center - Program staff not giving out phone numbers. Providers' calls are sent to our area from the call center with calls that have absolutely nothing to do with our area because we happen to answer our phones. We try to find out where to send the call, but, since we have no phone listing and most program areas are not allowed to give out their phone numbers, providers are being passed around the Department. In some instances when we call an area, we at the Department are even sent back to the call center. The call center has been described as being rude and not very informative on Medicaid subjects that they are being asked about.</p> <p>Recommendation: Provide a list of the contact person for each program area. Do not really need to know where they are located, but at least who it is and a contact's phone number. As for customer service, a policy of not giving out a phone number is BAD customer service. If the call center was given a list of different types of provider numbers, for example: RHC002 (Rural Health Clinics), NH2222 (Nursing Homes), they could at least know which area to send the call to in some instances. Again with an actual contact person, not an automated system.</p>	<p>Better program area training of call center staff is a priority goal of the Department.</p>
	<p>Providers call the United Way Call Center trying to get help in resolving claims. They are informed that they are to call the Provider Service Center. Their response is I call but did not get the help needed. When the provider cannot get paid they are billing the beneficiary.</p> <p>Recommendation: That the Provider Service Center is staffed with knowledgeable staff members and staff that is willing to provide the assistance that the providers need.</p>	<p>In line with previous comment related to PSC. An email has been set up for issues or escalated calls. If the beneficiary call center could get the name of the person the caller spoke with or Comm ID, then Email Medicaid.PSC@BCBSSC.com. If it is an escalated issue, place “Escalated Provider” in the subject line. A manager at PSC will review and call</p>

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		provider back.
	<p>Provider service center doesn't provide best direction to correct claims. Expertise is lacking.</p> <p>Recommendation: Would like a single contact to escalate to and receive good information</p>	SCDHHS has increased its focus on customer service initiatives in an effort to improve the quality of service provided.
	<p>Provider service center can only handle three issues at a time.</p> <p>Recommendation: Allow for more issues if they are similar</p>	The Provider Service Center does not have a limit on the number of issues they handle. SCDHHS has discussed this issue with the Provider Service Center Management and have been assured that this is not the case.
Reimbursement		
	<p>Receive reimbursement at 65% of OB rate. Have about 5 codes (59409, s8415, 99354, 99215, 99402).</p> <p>Recommendation: Would like reimbursement at 85% of reimbursement rate.</p>	This is a concern regarding rates which are not being addressed at this time.
	<p>Cannot be reimbursed for prolonged care. 99355 can be accepted by Medicare but not Medicaid.</p> <p>Recommendation: Look at coverage of 99355 for transition services from licensed midwife to hospital.</p>	SCDHHS will investigate this issue..
61 104 DHEC birth center regulations	<p>Birth Center owners are statutorily required (61 104 DHEC birth center regulations) to have second licensed provider in house during delivery, but Medicaid does not reimburse for second provider.</p> <p>Recommendation: Look at reimbursement for second licensed provider.</p>	SCDHHS will investigate this issue.
	<p>Birth centers are being paid on facility fee rather than facility service fee. Service fee includes second person, registered nurse, supplies, etc.</p> <p>Recommendation: Need a language change to facility service fee. Bill in ACA mandates that Medicaid covers facility service fee.</p>	Will take this recommendation under advisement and review provisions of ACA.
	<p>Medicaid uses nurse midwife rather than licensed midwife then MCO reimburses for licensed midwife rather than certified nurse midwife.</p> <p>Recommendation: Need separate codes for billing purposes and/or additional modifiers.</p>	Please make the appropriate distinction between the services that are allowed to be performed by a Licensed Midwife. All procedure codes must be filed with a "SB" modifier.
	<p>Physicians can come in and bill for delivery when a mother is brought in with certified nurse midwife.</p>	SCDHHS will investigate this issue.

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	<p>Recommendation: Need to pay nurse midwife for time spent. Physician should only be reimbursed for delivery.</p>	
	<p>Do not break even with Medicaid mothers. Only accepting 5 Medicaid recipients per month.</p> <p>Recommendation: Would like to take more Medicaid mothers. Get paid for home visits for FFS Medicaid, but MCOs do not pay for this.</p>	<p>The MCOs must accept the basic coverage options.</p>
	<p>80% of revenue is from Medicaid. Must go through DDSN and cannot bill directly. Operating on rates that were established in 2008.</p> <p>Recommendation: Direct bill would allow for higher rate.</p>	<p>SCDHHS is undergoing a comprehensive rate review for all DDSN rates and is also working the Local DSN board that has volunteered to investigate moving to direct bill.</p>
	<p>I have a small private practice as a counselor and geriatric care manager. This is a part time job (I also work part time at Oconee Medical Center). Last year I only made about \$7000 on the private practice business. I am a Medicare and Medicaid provider for mental health services.</p> <p>This month Medicaid (through SCDHHS) charged my small business \$532 to re-validate my enrollment in Medicare and Medicaid. The represents about 7% of my profit in 2013. I have heard several of my colleagues say that they were considering no longer accepting Medicare or Medicaid because of this new re-validation fee. Although none of them was considering closing their business, it does limit the care for the poor and the elderly if fewer counselors take Medicare and Medicaid. I think the US or SC government should bear the costs of validating providers (as they always have before). We need to do all we can to allow more counselors to take Medicare and Medicaid, not put hindrances in their way.</p> <p>Also, it hurts my business that Governor Halley declined the funds for Medicaid available from the Affordable Health Care act. Counselors such as me are often asked to help the poor with mental health services pro bono and we do this. But there is a limit to how many we can see, and each pro bono client I see means I have less time for a paying client. Many of the poor are suffering from mental health problems (depression because they couldn't find work; PTSD because of childhood abuse or military services; anxiety and panic disorders because of trauma in childhood and in poorly run schools and day care).</p> <p>Recommendation: I suggest SC take the federal funds from Obamacare which would provide additional health coverage for the poor. Money spent giving them additional health care would not only help me and my colleagues, but also help the poor to get better, get jobs, stay out of jail, and be better models for their children. Please reconsider the refusal that is hurting out state (and our small</p>	<p>CMS requires new enrollment fee as part of the ACA></p>

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	business providers). Taking the federal funds would also help the hospital where I work be more solvent since more people would have insurance. I am so pleased to hear about the states that are starting their own health insurance exchanges as a result of the new Affordable Care act. SC's decision to not take the federal funds makes me want to move to a state that has more concern for its poor and the sick and takes help to provide services for them. I find the Governor's argument about not taking the funds (SC would later have to pay for the increase) weak. It seems like she is unaware of the needs of the poor and sick when I hear her talk about taxes and federal programs.	
Disproportionate Share in Proviso 33.34	In addition to the current regulatory burdens addressed we would also like to comment on the proposed requirement concerning Disproportionate Share in Proviso 33.34. The Proviso would require hospitals to “obtain a patient attestation to determine whether or not the individual receiving uncompensated care has access to affordable health insurance or does not have other means to pay for services”. This will be an additional form to be signed by the patient increasing the administrative paper work burden for hospitals. Often determination of charity status or access to third party coverage occurs after the patient has been treated. We would also suggest that if this attestation is determined to be necessary, it be delayed until there is a better understanding of how the health insurance exchanges will work and no earlier than State Fiscal Year 2015.	SCDHHS has convened a project team for this proviso, which will include hospital stakeholders.
Affordable Care Act, Part II, Employer Responsibilities, Sections 1511 – 1513	While I understand that this review is not considering regulations established to meet federal requirements, my comments address South Carolina’s ability to provide personal care services once the insurance requirements of the Affordable Care Act take effect, specifically those found in Part II, Employer Responsibilities, Sections 1511 – 1513. My comments pertain to policy and procedural issues that affect an employer’s ability to successfully conduct business 2014 and thereafter. As you know, beginning in January 2014, employers that are deemed large employers under the Affordable Care Act will be required to provide affordable health insurance or pay a \$2,000 per employee penalty, with no penalty for the first 30 full-time employees. As a business owner with over 700 employees that provides services in 27 counties in our state, I am aware first hand of the challenges we face in providing great service to our clients. Among the array of services Nightingales Nursing & Attendants provides is skilled nursing care, respite care and in-home companionship. We are one of the largest providers in this market in South Carolina. Much of the work we do is with your Department. The hourly payment rates for home health care and other personal care categories currently do not include the cost for health insurance. Generally this has been an industry that does not provide health insurance as part of its compensation package. In fact, payment rates for the categories of care Nightingales provides is very close to the hourly rates we pay our employees. There is little margin, and in some cases no margin, for profit. For example, companion care is reimbursed below actual costs. However, we provide companion care and both levels of personal care because it is a service our clients need and as well as to provide a full complement of services to our community. We now are seeing RNs and LPNs being hired at rates that are dangerously close to our reimbursement, which when taken with the insurance costs, the risk involved and overhead, seriously	This is a rate issue and not a regulatory burden. SCDHHS will follow up directly with the Midwife Association.

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	<p>affect the program’s integrity. Trying to recruit and retain good nurses is difficult given that we compete with hospitals and nursing homes – both of which have better benefit packages. The constraint reimbursement rates currently place on compensation almost makes it impossible.</p> <p>Recommendation: We wanted to take this opportunity to urge SCDHHS to move forward with consideration to adjust payments made under these contracts to include the costs we will see this coming January. Costs for providing insurance will exceed \$6,000 per employee, plus any increases that will be seen in the large group market as a result of changes required by the ACA. Even with an employer paying 70 to 75% of the cost of insurance, the total cost of providing insurance will be between two and three dollars per work hour. Another option would be to not provide insurance and face the \$2,000 penalty. For Nightingale’s, the penalty would be over \$400,000 each and every year. Without adjustment in the payment rate, an employer’s only other option would be to reduce the number of full time employees.</p> <p>The insurance market is in a state not seen before with tremendous uncertainty in the marketplace. I have contacted two large insurance carriers, the largest in the state and one of the largest nationwide, Blue Cross Blue Shield of South Carolina and United Healthcare; neither would offer a quote. My understanding is that there is no requirement for any insurance company to write a policy in this market. And while South Carolina’s insurance exchange will become operational this fall, it will not be able to consider writing policies for large employers, those with more than 50 employees, until 2017.</p> <p>I appreciate your consideration of these issues. They do impact both the cost and quality of care in a market that is already a very challenging one in which to operate. I will be very happy to provide any additional information you or your staff may need.</p>	

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DHHS 149 Form, DHHS 151 form	<p>Another issue is the entire process of the nursing home room & board billing for nursing home/hospice-mutual patients. This NH billing is currently done by the hospice Department, on behalf of the nursing home (and in my humble opinion, there is no logical reason for this). The billings always run, at a minimum, a month behind. The nursing home is required to submit a TAD to Medicaid. The nursing home then, in turn, receives an ECF with a claim edit of 976 from Medicaid. This then prompts the NH to bill the hospice Department via a manual invoice. We then have to manually calculate the patient's daily NH rate, at a reduced 5% rate from what is shown on the ECF/invoice. Then, once again, a hardcopy claim is submitted to Medicaid. Upon receipt of these claims at Medicaid, they are then again manually entered at Medicaid – causing much room for error. Our NH room & board claims have denied numerous times due to keying errors on Medicaid's end; it is quite a burdensome process to get this straightened out. And to top it all off, the hospice must pay the NH at 100% of their invoice charges although Medicaid only pays 95% of those charges. This means we, the hospice Department, are paying 5% more to the NHs – again, extremely time-consuming as we are doing all the work, manual computations, and manual hardcopy submissions.</p> <p>Recommendation: Ironically, several years ago, we were allowed to submit these NH room & board claims electronically, via Web Tool. In today's medical-electronic world, manual calculations and hardcopy submissions should be a thing of the past! Better yet, regarding this nursing home room & board billing, the hospice should be taken out of the picture completely.</p>	<p>Staff is currently making revisions to claims submission policies and procedures. A team has met to discuss reverting back to electronic claims submission for all Hospice/Nursing Facility room and board claims (T2046). This will expedite payment. SCDHHS will also work with Medicaid Program Integrity on post payment reviews.</p>
	<p>Problem: The Licensed Midwives (LMs) are reimbursed at 65% of the physician rate.</p> <ul style="list-style-type: none"> • This creates a very LOW fee collected by providers for full-service prenatal, labor, birth, postpartum, and newborn care. The average fee for a normal, healthy woman and newborn, for ALL care provided, ranges from \$1100 to \$1800, depending on when she enters into care with the LM. The average self-pay fees for LMs range from \$2400-\$4000 for home birth. • The average prenatal visit with an obstetrician is 5-8 minutes long. Depending on the weeks' gestation, and the topics at hand to discuss, the LM spends an average of 45-90 minutes with each client, at each appointment. • The average face-to-face time spent delivering labor, birth, and postpartum care to a first-time mother, who is a Medicaid recipient, in my practice, has been 12 hours, since my business opened in 2007. This is in home, one-on-one care, not being provided by nurses, assistants, etc. • The cost savings by increasing reimbursements to LMs, and encouraging more midwives to accept Medicaid, will be multi-factorial. Data specific to LM care is difficult to obtain, but the January 2013 study "Outcomes of Care in Birth Centers: Demonstration of a Durable Model" provides current, applicable, significant, and fiscally-impressive data, as five of the six licensed birth centers in SC are owned and operated by LMs. <p>o Medicaid facility reimbursement for birth centers varies widely across states in which birth centers</p>	<p>SCDHHS will follow up directly with the Midwife Association.</p>

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	<p>are reimbursed; however, in 2011, the average Medicaid reimbursements in general were similar to national Medicare reimbursement rates. The Medicare facility reimbursement for care of mother and newborn for an uncomplicated vaginal birth in a hospital in 2011 was \$3998, compared with \$1907 in a birth center. Thus, the 13,030 birth center births in this cohort saved an estimated \$27,245,469 in payments for facility services compared with hospital vaginal births at current Medicare rates. Even with birth center facility reimbursement rates increased to more equitable levels, cost savings would remain significant.</p> <ul style="list-style-type: none"> • The cesarean birth rate in this cohort was 6% versus the estimated rate of 25% for similarly low-risk women in a hospital setting. Had this same group of 15,574 low-risk women been cared for in a hospital, an additional 2934 cesarean births could be expected. The Medicare facility reimbursement for an uncomplicated cesarean birth in a hospital in 2011 was \$4465. Given the increased payments for facility services for cesarean birth compared with vaginal birth in the hospital, the lower cesarean birth rate potentially saved an additional \$4,487,524. In total, one could expect a potential savings in costs for facility services of more than \$30 million for these 15,574 births. <p>Recommendation: Increase the Licensed Midwives reimbursement rate to 85% of the physician rate.</p>	
	<p>Problem: Licensed Midwives are authorized to bill for exceedingly limited ICD-9 and CPT codes that do not adequately reflect the services provided.</p> <ul style="list-style-type: none"> • LMs are required to bill under a specific modifier, and there are approximately 25 Evaluation/Management codes for which we are able to receive reimbursement. There are 4 diagnostic codes that we are permitted to use. These extreme limits, in no way, reflect the full scope of services we provide to mothers and babies. • One example: when a woman has a need to transfer care to a hospital for a prolonged labor, the LM may only bill for services that result in reimbursement of \$163.23. This typically happens after many, many hours of one-on-one, direct care. Private insurance carriers will permit providers to bill 99355, which is defined as Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g.: prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes (List separately in addition to code for prolonged physician service). It IS a code that is reimbursable by Medicare; see Attachment 1. • Expanding the billable codes to the full repertoire will permit more accurate coding, which aligns with the National Correct Coding Initiative begun in August, 2011. <p>Recommendation: Eliminate the burdensome limitations on the allowable coding for LMs during the transition to ICD-10, permitting us to more accurately bill for the services provided.</p>	<p>SCDHHS will follow up with the Midwife Association.</p>
	<p>Licensed Birth Centers in the state of South Carolina are required by regulation to have a second care</p>	<p>SCDHHS will follow up with the</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
	<p>provider (LM, CNM, RN, MD) present for each birth. However, Medicaid does not allow us to bill for that second care provider. This affects the primary midwife who then must compensate the second required person thereby reducing her already low compensation.</p> <p>Recommendation: Allow for this second care provider to bill for themselves at a reasonable rate.</p> <p>Dr. David Anderson, Professor of Economics and Specialist in Out-of-Hospital Birth Economics, at Centre College in Kentucky, has studied the cost-effectiveness of home birth for over a decade, and his “Notes on the Economics of Out-of-Hospital Maternity Care” [Attachment 2] includes the following:</p> <p>*If we increased the home birth rate to just 5%, we would realize a savings of \$1.3 billion annually. *If we increased the number of birth center deliveries by the same modest amount, we would add \$674 million in savings. Factoring in the reduced cesarean section rate that accompanies out-of-hospital delivery under the care of Certified Professional Midwives, we would see an additional savings of \$341 million annually. *Factoring in the reduced costs that would result from the reduction in preterm and low-birth weight deliveries would add another \$84 million in savings each year. *If the cost of routine hospital deliveries and the inflated cesarean section rate was reduced by as little as 15% due to increased competition in the maternity care market, we would realize an additional \$3.5 billion in annual savings. Total annual savings realized by expanding access to Certified Professional Midwives and Out-of-Hospital Maternity Care: \$9.1 billion</p>	Midwife Association.
	<p>Regulations require 2 midwives during deliveries, but not paid for second.</p> <p>Recommendation: Would like reimbursement for second midwife.</p>	SCDHHS will follow up with the Midwife Association.
	<p>No codes for breastfeeding.</p> <p>Recommendation: Align payment with nurses who are reimbursed for breastfeeding appointments.</p>	SCDHHS will follow up with the Midwife Association.
	<p>Not allowed to use code to bill for transfer.</p> <p>Recommendation: Allow use of code.</p>	SCDHHS will follow up with the Midwife Association.
Third Party Liability		

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
OBGYN billing, insurance, collections, etc.	Why is it when a pregnant patient has a Commercial Insurance, (i.e. Aetna, BCBS, etc.) and Medicaid secondary that the Medicaid doesn't pay like a secondary if it was a Commercial Insurance? It should be treated the same as if someone had BCBS primary and say Aetna secondary. If BCBS pays more than the secondary allows, no money is due the provider.	Please refer to the Provider Manual, Section 1: General information and administration, Medicaid as payment in full. Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) <u>as payment in full</u> . Medicaid is not commercial insurance; it is a payer of last resort.
OBGYN billing, insurance, collections, etc.	When a patient has both commercial insurance and Medicaid, the primary is filed, but if the Global payment is less than each visit that we are allowed to charge Medicaid, plus the delivery and sometimes even postpartum charge, we have to refund the primary and file the secondary and Medicaid pays. It's called pay and chase. Why isn't Medicaid global like Commercial insurance?	Please refer to the Provider Manual, Section 1: General information and administration, Medicaid as payment in full. Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) <u>as payment in full</u> . Medicaid is not commercial insurance; it is a payer of last resort.
	Other Health Insurance updates are not timely. Recommendation: Need timely updates, including update to MCO	SCDHHS is addressing this through process improvement projects, which should result in quicker updates.
Training		
	<p>Organization must be a current Medicaid provider before attending "Live Provider Workshops." The website lists Medicaid Basics Training workshops as offered once a month.</p> <p>Knowledge about this requirement was obtained when attempting to enroll in a training course online and by the phone. Online there was a required box for provider number. The SCDHHS staff on the phone did not know where to find this requirement in writing. But stated "unfortunately you must be a provider to register." We are currently working to meet the SCDHHS requirements of becoming accredited in an effort to enroll as a Medicaid Provider. We anticipate obtaining national accreditation through Council of Accreditation ("COA") by June 30, 2013. As we strive to meet requirements for COA and Medicaid Provider enrollment, we believe it beneficial to receive Medicaid Basics training prior to our acceptance as a Medicaid provider to ensure our programs have the required appropriate</p>	SCDHHS can make it an optional field and have it state, "Please provide your provider number if you have one." If not, tab to next field.

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	SCDHHS Comments
	<p>staff and policies in place. Pendleton Place for Children and Families is seeking ways to improve quality and efficiency throughout each of our programs and Department as a whole. Therefore, receiving Medicaid Basics Training would be beneficial for all parties involved as it permits:</p> <ul style="list-style-type: none"> • State agencies and affiliate programs time to properly plan for staffing needs (i.e., training) and hiring of appropriately credentialed staff • Agencies additional time to make necessary changes in policy, procedures and daily operations to meet Medicaid requirements • Agencies and programs to minimize the number of errors submitted for Medicaid claims submissions • Agencies and programs with the means to serve the community based on early receipt of information and knowledge regarding Medicaid Standards and Policies. <p>Recommendation: Receive Medicaid Basics training prior to our acceptance as a Medicaid provider</p>	
Transportation		
NEMT	<p>Non-emergent transport services need to be enhanced and education provided to the carrier(s).</p> <ul style="list-style-type: none"> *Difficulty in arranging transport for patients with oxygen is frequently expressed by hospital discharge planners. * Length of time waiting for the transport is an issue even though the 3 hour notice was honored. Delays cause a backup in the ED and inpatient areas when hospitals cannot discharge non-acute patients for the intake of new patients. * Appropriate method of transport is also a concern expressed with the overuse of ambulance services. * Getting authorization in a timely manner is an issue expressed by hospitals. * Carrier staff knowledge is frequently a stumbling block to an efficient process and written policies and procedures with required education is an effective way to make quick corrections. 	<p>With the end of the current transportation broker contract next year, the Department is in the process of gathering provider and stakeholder input on the NEMT process. Two open forums have been held and a Logic Document is posted to the Department's website that identifies the concerns and recommendations that have been identified. The document also includes Short, Medium and Long Term goals for addressing the concerns. A short term objective is to arrange a meeting and/or conference call with hospital discharge planners to gather more information. This is planned within the next month.</p>

B. GLOBAL RECOMMENDATIONS

As SCDHHS has studied the burdens and recommendations received from internal and external stakeholders, several recurring themes were identified. In light of this, SCDHHS has identified the following global recommendations that apply broadly to its operations:

- **Policy Management:** SCDHHS manages an extensive set of policies relating to providers, beneficiaries, claims operations and other business areas. At present, individual business areas manage these policies.

Recommendation: Similar to the centralized Project Management Office, which manages projects across the Department, SCDHHS would benefit from creation of a centralized policy area to manage all Department policies and serve as the single authority on all policies. This area would also ensure that a recurring, comprehensive review of all policies took place, which would account for any changes needed such as a revision prompted by a change at the Federal level.

On a related front, a key consideration of the policy area would be to consolidate policies as necessary. At present, there are a few dozen provider manuals available via the SCDHHS website. Much of the content of these manuals remains the same across the provider types. Consolidating these policies would reduce the number of information sources a provider must consult and would simplify the Department's policy update process.

- **Communication:** Though the Department has many venues to communicate information to providers, beneficiaries and other stakeholders, most communication methods utilize a "pull" method rather than a "push" method. That is, stakeholders must seek out information on changes rather than receive information via a subscription service or other automated method.

Recommendation: SCDHHS plans to enhance its communication methods to ensure the right information reaches the right sources. For example, automatic enrollment in electronic bulletins at the point of provider enrollment and increasing direct communication to beneficiaries (e.g., newsletters, eblasts, text messages) are potential ways that the Department could enhance its communication efforts.

- **Provider Relations and Outreach:** A vast majority of the Department's regulatory impacts are through our relationships with our Providers. These providers of services include medical practices, hospitals, clinics, pharmacies, dental offices, physicians etc. We had a large number of comments about the burdens on these businesses that result from not being able to get the proper support for questions on all types of issues including claims payment, enrollment, claims submission, covered services, eligibility etc.

Recommendation: SCDHHS would like to develop better processes and procedures in the provider service center, including enhancing training of front line staff to be more knowledgeable to solve problems and answer questions in a more expeditious manner. The Department is also interested in developing a better provider relations and outreach

plan for the state to give a more personalized and expert handling of provider concerns and issues, including provider representatives placed throughout the state to provide individual attention for trouble-shooting and problem solving.

C. REGULATIONS AND STATUTES

The following table is a comprehensive review of the Department's statutes and regulations. The SCDHHS Office of General Counsel and program staff conducted a review of the statutes and regulations and identified any changes as necessary. Comments are included to indicate the change needed.

As a result of this review, the Department recommends deleting two entire sections of statutes and two entire sets of regulations. The statutes that can be deleted address Child Development Services and Intermediate Sanctions for Medicaid Certified Nursing Facilities. The regulations that can be deleted address Social Services Block Grants and Intermediate Sanctions for Medicaid Certified Nursing Facilities. In the case of Child Development Services and Social Services Block Grants, SCDHHS transferred these programs to DSS, which is now charged with their administration and monitoring. The Intermediate Sanctions can be deleted as well because CMS promulgated its own regulations to address nursing facilities, and DHEC is the state Department charged with regulating nursing facilities. Therefore, there is no longer a need for these provisions in SCDHHS' statutes and regulations.

While it became apparent during the Department's review that there were some burdensome or unnecessary provisions for providers, it also became apparent that the Department's regulatory guidance as a whole requires an update. Several provisions are no longer effective due to program transfers or events that occurred ten or more years ago. For example, the Department is still referred to as the Health and Human Services Finance Commission throughout the statutes and regulations. Provisions have often not been updated to correspond with changes in federal law or with rulings from courts. Very often no guidance is provided in the provisions as they often solely grant the Department authority to regulate a certain program without further information. The Department received some comments from providers requesting additional regulations or to provide more guidance on certain topics. The message from some providers has been that no guidance can be just as burdensome to a provider as too much.

Therefore, the Department recommends a review of its current statutes and regulations with a goal of pre-filing regulations for consideration by the General Assembly in December 2013 and on a regular basis afterward. The purpose of these proposed regulations would be to clean up our current statutes and regulations, make amendments where necessary, delete unnecessary provisions, and provide more guidance where requested. Additional guidance will also need to be promulgated in statute and/or regulation to include necessary and appropriate changes associated with the Affordable Care Act as well as the implementation of new or changing initiatives at the Department (i.e.: OSCAP implementation).

Statute or Regulation	Title	Change needed?	Description of Change	Comments
STATUTES				
GENERAL PROVISIONS		Yes	Generally update to remove references to the Health and Human Services Finance Commission	
§ 44-6-5	Definitions			
§ 44-6-10	Creation of commission; members; term; conflicts of interest			
§ 44-6-30	Duties and limitations			
§ 44-6-40	Duties	Yes	Delete administration of the Social Services Block Grants from list of enumerated powers	DHHS no longer administers SSBG; this program was transferred to DSS in 2003
§ 44-6-45	Authority of Commission to collect administrative fees associated with accounts receivable for those individuals or entities which negotiate repayment to Department			
§ 44-6-50	Contracts with other agencies; program monitoring			
§ 44-6-70	Preparation of state plan and resource allocation recommendations			
§ 44-6-80	Annual and Interim Reports			
§ 44-6-90	Promulgation of regulations; other agencies to cooperate with Commission			
§ 44-6-100	Personnel of Commission; duties; compensation			
MEDICALLY INDIGENT ASSISTANCE ACT		Requires further investigation	Assess program	The taskforce recommends the Department reconsider the practicality and feasibility of maintaining the MIAP program. Several counties no longer have individuals who process MIAP applications, and hospitals often utilize their own indigent programs. However, with reductions in DSH payments, this program may become more viable in the near future.

Statute or Regulation	Title	Change needed?	Description of Change	Comments
§ 44-6-132	Legislative findings and intent			
§ 44-6-135	Short title			
§ 44-6-140	Medicaid hospital prospective payment system; cost containment measures			
§ 44-6-146	County assessments for indigent medical care; penalties for failure to pay assessments in timely manner			
§ 44-6-150	MIAP; reporting of charges for sponsored patients; duties of commission; duty to provide unreimbursed medical care to indigent persons			
§ 44-6-155	Medicaid Expansion Fund			
§ 44-6-160	Target rate of increase for net inpatient charges; excessive increases; penalties			
§ 44-6-170	Collection and release of health care related data; confidentiality; regulations to be promulgated; Data Oversight Council; Health Data Analysis Task Force; hospital to provide required information; violations and penalties			
§ 44-6-175	Annual reports to be provided to Division of Research and Statistical Services			
§ 44-6-180	Confidentiality of patient records; controlled dissemination of data; violations and penalties			
§ 44-6-190	Applicability of APA; compliance with Medicaid disclosure rules			
§ 44-6-200	Falsification of information; penalties			
§ 44-6-220	Notice requirements on nursing home admission applications			
CHILD DEVELOPMENT SERVICES				
§ 44-6-300	Child development services to be established	Yes	Delete all provisions	Child Development Services, which is administered pursuant to Title XX, was transferred to DSS in 2003. The transfer was pursuant to an agreement between the agencies, an executive order, and the eventual transfer of

Statute or Regulation	Title	Change needed?	Description of Change	Comments
				funding in the state budget. As these provisions address the administration of a program we no longer operate, they should be deleted.
§ 44-6-310	Expansion of existing child development services	Yes	Delete	
§ 44-6-320	Appropriations	Yes	Delete	
INTERMEDIATE SANCTIONS FOR MEDICAID CERTIFIED NURSING HOME ACT				
§ 44-6-400	Definitions	Yes	Delete all provisions	These provisions address sanctions for nursing homes and were promulgated before CMS issued its own regulations. At this time, CMS has federal guidelines in place, and DHEC has been vested with regulation and compliance of nursing homes. Therefore, these provisions can be deleted.
§ 44-6-420	Enforcement actions; considerations; proportionality to violations	Yes	Delete	
§ 44-6-470	Fines; use of funds collected	Yes	Delete	
§ 44-6-530	Federal jurisdiction	Yes	Delete	
§ 44-6-540	Authority for rulemaking and to ensure compliance with Medicaid participation	Yes	Delete	
GAP ASSISTANCE PHARMACY PROGRAM FOR SENIORS ACT		No		
§ 44-6-610	Citation of article			
§ 44-6-620	Definitions			
§ 44-6-630	Creation of GAPS program; purpose			
§ 44-6-640	Administration of program; assistance of other agencies or organizations; enrollment fee			
§ 44-6-650	Eligibility; benefits			
§ 44-6-660	Evaluation of cost effectiveness; annual report			

Statute or Regulation	Title	Change needed?	Description of Change	Comments
TRUSTS AND MEDICAID ELIGIBILITY				
§ 44-6-710	Treating application of person deemed ineligible because of Medicaid qualifying trust as undue hardship case	Yes	Update where necessary	Given the proliferation of new documents and tools used in estate planning and in general, these provisions may require an update to address current circumstances.
§ 44-6-720	Requirements for qualifying for undue hardship waiver			
§ 44-6-725	Promissory notes received by Medicaid applicant or recipient			
§ 44-6-730	Promulgation of regulations to implement article and comply with federal law; amendment of state Medicaid plan consistent with article			
RECOGNITION AND DESIGNATION OF FQHC AND RURAL HEALTH CLINICS				
§ 44-6-910	FQHCs, Rural Health Clinics recognized, designated; contracted entities in state health care system	Yes	Update where necessary	Given the Department's focus on incorporating these types of clinics into beneficiaries' care, the Department may want to promulgate additional regulations
MEDICAID PHARMACY AND THERAPEUTICS COMMITTEE				
§ 44-6-1010	Pharmacy and Therapeutics Committee established; membership	Yes	Update where necessary	Revisions may be necessary to reflect the increasing presence of MCOs, which have their own pharmacy guidelines and policies
§ 44-6-1020	Adoption of bylaws; election of chairman and vice chairman; compensation; meetings; public comment on clinical and patient care data from Medicaid providers			
§ 44-6-1030	Recommendation of therapeutic classes of drugs to be included on preferred drug list			
§ 44-6-1040	Preferred drug list program; procedures to be included			
§ 44-6-1050	Prior authorization for drugs; refills; appeals			
REGULATIONS		Yes	Generally, update text to remove references to the Health and Human Services Finance	

Statute or Regulation	Title	Change needed?	Description of Change	Comments
			Commission	
ADMINISTRATION				
R.126-125	General	No		
R.126-150	Appeals and Hearings - Definitions	Yes	Require a hearing officer to also be an attorney	We received a suggestion that all hearing officers should be attorneys. The Department has recently hired some contract hearing officers who are attorneys.
R.126-152	Appeal Procedure	Yes	Revisions to update regulations to reduce the burden of appeals on providers. Also update section to address appellate procedure for appeals arising from the Exchange.	Based on feedback received from providers, it would ease a burden on them not to require a face-to-face hearing. Options including hearing by video conference or other means could be reviewed. The possibility of using video conferencing rather than face to face should be considered. DHHS has contractors with staff not in Columbia and that adds a travel burden that ultimately impacts cost to the Department as well as to providers. Additionally, new appeal procedures should be promulgated to recognize and address appellate procedure for appeals arising from the Exchange.
R.126-154	Hearing Officer	Maybe	Revise to include additional powers of the hearing officer that have been called into question in appeals (i.e.: request a party to clarify its complaint or issue a more definite statement of issues on appeal, etc.)	
R.126-156	Prehearing Conferences			
R.126-158	Hearing Procedures			
R.126-170	Safeguarding Client Information – General	Yes	Revise to address the tension between HIPAA and the Safeguarding rules. May also put HIPAA compliance into regulation.	

Statute or Regulation	Title	Change needed?	Description of Change	Comments
R.126-171	Protected Information			
R.126-172	Purposes Directly Connected to the Administration of the Programs and Grants			
R.126-173	Release of Information			
R.126-174	Distribution of Materials to Recipients and Providers			
R.126-175	Penalties			
MEDICAID				
Scope of the Program		Yes	Update list of services	
R.126-300	General			
R.126-301	Services Covered by the Medicaid Program			
R.126-302	Audiology Services			
R.126-303	Certified Nurse Midwifery Services			
R.126-304	Community Long Term Care Home and Community Based Services			
R.126-305	Dental Care			
R.126-306	Durable Medical Equipment			
R.126-307	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services			
R.126-308	End Stage Renal Disease Services			
R.126-309	Family Planning Services			
R.126-310	Hospital Services			
R.126-311	Laboratory and X-ray Services/Tests			
R.126-312	Medical Transportation Services			
R.126-313	Mental Health Clinic Services			
R.126-314	Nursing Facility Services			
R.126-315	Physicians' Services			
R.126-316	Podiatry Services			
R.126-317	Prescribed Drugs			
R.126-318	Psychiatric Facility Services			
R.126-319	Rehabilitative Services			
R.126-320	Rural Health Clinic Services			
R.126-321	Speech Pathology			
R.126-322	Tubercular Facility Services			
R.126-323	Vision Care			

Statute or Regulation	Title	Change needed?	Description of Change	Comments
R.126-335	Hospital Reimbursement			
Eligibility for the Medicaid Program		Yes	General updates/changes to reflect provisions of the ACA as needed	Change provisions to reflect MAGI calculations, among other ACA provisions, and to set forth how eligibility determinations by the Exchange will be handled by this Department
R.126-350	Definitions			
R.126-355	Application Procedures	Yes	General updates/changes to reflect provisions of the ACA as needed. Need to include Federal Exchange and Streamlined Application.	
R.126-350	General Requirements			
R.126-365	Categorically Needy Eligible Groups	Yes	Remove reference that those eligible for AFDC are automatically eligible for Medicaid	
R.126-370	Redetermination of Categorically Needy Eligibility			
R.126-375	Medical Institution Vendor Payments			
R.126-380	Denial, Termination, or Reduction of Benefits			
R.126-399	Conflict Between State and Federal Regulations			
PROGRAM EVALUATION				
Administrative Sanctions against Medicaid Providers				
R.126-400	Definitions	Yes	Update definitions to reflect those under federal law.	
R.126-401	Sanctions	Yes	Remove Overpayment from Sanctions.	
R.126-402	Factors for Sanction	Yes	Consider making this more like sentencing guidelines - mitigation factors and exacerbating factors	
R.126-403	Grounds for Sanction			
R.126-404	Fair Hearings			
R.126-405	Reinstatement			

Statute or Regulation	Title	Change needed?	Description of Change	Comments
Program Integrity				
R.126-425	Recipient Utilization			
MEDICALLY INDIGENT ASSISTANCE PROGRAM (MIAP)		Yes	As stated in the statutory section, review this program to determine whether it should be maintained given the circumstances.	
Eligibility for MIAP				
R.126-500	Definitions			
R.126-505	Responsibilities for Eligibility Determination			
R.126-510	Application Process			
R.126-515	Non-Financial Eligibility Requirements			
R.126-520	Financial Eligibility Requirements			
Covered Services				
R.126-530	Services Covered by the MIAP			
R.126-535	Sponsorship From the MIAP			
R.126-540	Recovery by the MIAP			
Payment Process				
R.126-560	Payment System			
County Assessments				
R.126-570	Grace Period			
SOCIAL SERVICES BLOCK GRANTS		Yes	Delete provisions	SSBG was transferred to DSS in 2003 along with the Child Development BG.
R.126-710	General	Yes	Delete	
R.126-720	Scope of Program and Services	Yes	Delete	
R.126-730	Persons Eligible to Receive Social Services	Yes	Delete	
R.126-740	Application Procedures	Yes	Delete	
R.126-750	Client Right to Appeal	Yes	Delete	
R.126-799	Prior Regulations	Yes	Delete	

Statute or Regulation	Title	Change needed?	Description of Change	Comments
INTERMEDIATE SANCTIONS FOR MEDICAID CERTIFIED NURSING FACILITIES		Yes	Delete provisions	CMS has promulgated federal regulations addressing sanctions, and DHEC is the state Department charged with regulating and monitoring compliance
R.126-800	Definitions	Yes	Delete	
R.126-810	Imposition of Sanctions	Yes	Delete	
R.126-820	Factors for Sanctions	Yes	Delete	
R.126-830	Assessment of Sanctions	Yes	Delete	
R.126-840	Schedule of Sanctions	Yes	Delete	
R.126-850	Levying of Sanctions	Yes	Delete	
OPTIONAL STATE SUPPLEMENTATION PROGRAM		Yes	Update to reflect OSCAP changes	Prepare regulations for promulgation setting forth the new requirements, standards, and details of the OSCAP program.
R.126-910	Program Definitions			
R.126-920	Eligibility			
R.126-930	Termination, Suspension or Reduction of Benefits			
R.126-940	Program Administration			

3.0 NEXT STEPS

SCDHHS and its stakeholders quickly identified burdens on its beneficiary population that require further research and investigation. Therefore, SCDHHS will continue its effort by identifying policies, procedures, regulations and statutes that impose burdens on beneficiaries as a second phase of this project. The beneficiary-related comments received during this solicitation of comments will be addressed in this second phase of the regulatory burden effort. SCDHHS intends to follow a similar format in soliciting oral and written public comments. The exact method of collection of additional public comments is to be determined. SCDHHS intends to formally kick-off this effort in June 2013.

As a result of this initial investigation of the Department's regulatory burdens, SCDHHS will continue to follow-up and monitor its process improvement efforts. Certain efforts are currently tracked via the Project Management Office and will continue to receive this level of oversight. Other efforts will be managed by the appropriate business area with oversight from the business area's management. New efforts will be evaluated on a case-by-case basis to determine the level of monitoring required.

4.0 CONCLUSION

SCDHHS welcomes the opportunity to identify unnecessary burdens created by its policies, procedures, regulations and statutes and make recommendations on changes needed. Engaging stakeholders in this process was very effective and offers a new perspective as the Department looks to improve its operations and bring the highest quality of service to the citizens of South Carolina.

The Department looks forward to continuing this effort with other cabinet agencies and the Office of the Governor.

5.0 APPENDIX A: PUBLIC COMMENTS RECEIVED

Note: Contact information for submitters is available to the Task Force Committee upon request.

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information	Media
Appeals			
42 C.F.R. 431.244(g)	<p>Not having the decisions available online in searchable format results in a substantial burden for anyone seeking to review them. Businesses as well as individuals have hearings at DHHS.</p> <p>Recommendation: SCDHHS should comply with 42 C.F.R. 431.244(g), which provides that the public must have access to all Department hearing decisions, subject to the requirements of subpart F of this part for safeguarding of information, by posting all hearing decisions in a searchable form. SCDHHS should also post decisions of the Administrative Law Court and any other judicial body considering Medicaid issues.</p>	Nancy C. McCormick, Attorney at Law Protection and Advocacy for People with Disabilities, Inc.	email
South Carolina Regulation, Chapter 126, Article 1, Sub-article 3	<p>Modernize the DHHS appeal process regulation to be a less intensive and expensive process and allow a review by a separate and qualified auditor instead of the auditor denying the claim in question.</p> <ul style="list-style-type: none"> · South Carolina Regulation, Chapter 126, Article 1, Sub-article 3 · The current appeal process requires a face-to-face hearing and is very costly and time-consuming for all concerned parties. · The increase in post-pay review of claims has increased the need for change. 	James R. Walker, Jr. Senior Vice President, Regulatory and Workforce South Carolina Hospital Association	email; hand-delivered
Audits			
	<p>30 day window to file and mail in appeal</p> <p>Recommendation: Would like larger appeal window and online filing</p>	Brice Elvington	Florence Forum
R. 126.150-58	<p>SCDHHS should review its fair hearing regulation, R. 126.150-58, for conformity with the state Administrative Procedures Act. Hearing officers should be attorneys. The regulations should include procedures for discovery.</p>	Nancy C. McCormick, Attorney at Law Protection and Advocacy for People with Disabilities, Inc.	email
	Audits do not provide feedback for months.	Brice Elvington/	Florence Forum
Behavioral Health			
	In 2010, DHHS changed regulations around Rehabilitative Behavioral Health Services and an updated provider manual was put into effect. Prior to this change, services for therapeutic foster care were	Bethany R Vause, Executive Director	USPS

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information	Media
	<p>bundled allowing our staff members to document services rendered on a weekly basis. With the updated Rehabilitative Behavioral Health Services manual both our staff and foster parents need to document after each service rendered. The need for therapeutic foster parents to complete daily documentation along with the administrative duties for staff has been quite burdensome.</p> <p>Recommendation: Due to the heavy burden that unbundling the services for therapeutic foster care has caused we would like to recommend therapeutic foster care services become bundled once more.</p>	Lutheran Services Carolinas	
Claims Processing			
	<p>Exceedingly limited ICD-9 codes. Have 4 codes in ICD-9. Approximately 25 in CPT codes. Does not encompass full scope of care</p> <p>Recommendation: Crosswalk for ICD-9 to ICD-10.</p>	Brandy Brandfass/ Licensed midwife Charleston Midwife/ President of Midwife Association	Charleston forum
	<p>Cannot meet NCCI standard. Will get rejected if use code 12, which is place of service of home. Have to use code 11.</p> <p>Recommendation: Need the ability to bill a code 12.</p>	Brandy Brandfass/ Licensed midwife Charleston Midwife/ President of Midwife Association	Charleston forum
	<p>Cannot be reimbursed for prolonged care. 99355 can be accepted by Medicare but not Medicaid.</p> <p>Recommendation: Look at coverage of 99355 for transition services from licensed midwife to hospital.</p>	Brandy Brandfass/ Licensed midwife Charleston Midwife/ President of Midwife Association	Charleston forum
	<p>DHHS has a manual paper process of providing the KeyPRO organization with the necessary retroactive Medicaid eligibility load date which is a condition precedent to granting a retro prior authorization for a hospitalization. <i>Note: Submitter provided background and detailed discussion not included here.</i></p> <p>Recommendation: Either enhance the daily electronic report sent to KePRO to include any retroactive Medicaid eligibility load dates or provide an electronic mechanism for hospitals to be able to research the retroactive load date and provide acceptable proof to KePRO of that load date.</p>	Rob Murr, Regional Vice President Chamberlin Edmonds & Associates (CEA)	FedEx
Processing System	<p>Aged and outdated systems for claims adjudication and enrollment should be replaced for a more efficient and economical process. Aged Processing System Detail:</p> <ul style="list-style-type: none"> · Providers must often resubmit claims multiple times due to the lack of system capabilities. · NDC crosswalk is not updated timely causing extra work for providers and the Department. · Fee schedules are not updated timely causing costly payment errors that must be adjusted or reprocessed. 	James R. Walker, Jr. Senior Vice President, Regulatory and Workforce South Carolina Hospital Association	email

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	<ul style="list-style-type: none"> · Reprocessing of claim batches without notice to the providers causing unnecessary and expensive denials that must be resubmitted and reprocessed. · Edit capabilities are limited thus requiring additional staff for a manual process for claims adjudication. · Audits and Department funds are compromised by lack of electronic means of managing business requirements and are burdensome on providers as indicated in the following DHHS audit letter paragraph comments: <ul style="list-style-type: none"> o “We have preliminary data analysis which shows that there are overpayments that were not identified and captured through the Department’s coordination of benefits processes, by the federal Medicaid Integrity Audit Contractor (MIC) audits, or by credit balance audits conducted by other audit firms.” o “We recognize that for some patient accounts the hospital may have already identified the overpayment and refunded DHHS. However, these refunds do not show up in our claims data since the individual claim is not adjusted on a post-payment basis.” o “The time frame for this review will begin with May 2011 and will continue as we get new paid claims data. The Hospital Services Provider Manual was updated on September 1, 2011 to reflect SCDHHS payment policy. MMIS does not have the capacity to correctly process the claim. It is our intention to conduct this audit on an ongoing basis until the MMIS system can be corrected.” 		
KePRO Retro-enrollment Process	Retro-enrollment and the KePRO prior authorization process. KePRO needs access to the actual date of retro-enrollment approved for Medicaid recipients in order to prevent the burden of requiring a hospital to provide documentation of the DHHS process. The lack of system capability is the cause of unnecessary denials of hospital admissions and duplicate work on behalf of hospitals, KePRO and DHHS. DHHS acknowledged a correction process to this burdensome arrangement last summer but does not have a date of completion.	James R. Walker, Jr. Senior Vice President, Regulatory and Workforce South Carolina Hospital Association	email; hand- delivered
	<p>From the Medicaid Provider Manuals that govern the practice should be referenced when looking at the following comments.</p> <p>The specific process of obtain authorizations for clients is cumbersome and time consuming. I am only allowed to take clients who are referred to me by another LPHA, specifically a physician. The physician signs off for the initial assessment, faxes to another Department, not Medicaid, for an authorization just for the assessment. That is the first authorization. Then a Medical Necessity Form is required for the second authorization for treatment. Again the process starts with the clinician filing out the form, faxing to the physician to sign, fax back, then it is faxed to the outside Department for authorization, not Medicaid. (If a clinician is on an insurance panel, most companies that require authorizations are a one phone call or one form to obtain a certain number of visits for treatment and you are done.)</p> <p>Medicaid also requires an inappropriate amount of paperwork for completion of the file. Medicaid also requires separate meetings for treatment plan formulation, invitations in the file to other parties</p>	John M. McLain, MS, LMFT McLain Therapy and Counseling Services	email

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	<p>involved for the formulation of goals. The client, family and the clinician should be all that is required for the formulation of goals of treatment. If the family is bringing the client to treatment why does there need to be an invitation to a meeting to formulate goals that they are already a part of? The goals do not need to be in a separate form (IPOC) when they can be specified in the progress notes (CSN). The completion of these additional forms and/or other paperwork takes away from the treatment of the client, plus the clinician is not reimbursed for the extra time for completion of the forms. (Insurance companies do not require this amount of paperwork or complication.)</p> <p>Recommendation: Please streamline the authorization process and required paperwork. Each of these two parts can be done in a more efficient manner. One phone call to a Medicaid representative to give an authorization for an assessment and a certain number of visits would be adequate. Much of the paperwork could be incorporated into the progress notes without additional forms or requirements.</p>		
<p>SC Medicaid Manual, Section 6</p>	<p>Section 6 of the SC Medicaid manual dated 10/01/12 and the SC Medicaid bulletins dated 07/09/12 and 12/12/12. The Birth Outcomes Initiative policy that Medicaid implemented to be effective 01/01/13 has caused our practice a huge negative impact. We have not been paid on any delivery claims since 01/01/13 for patients that delivered prior to 39 weeks. The bulletin asks for practices to submit Medicaid approved diagnosis codes and report the appropriate modifier. Not in any bulletin or policy did it say this would require the provider to send hard copy documentation along with the claim or the documentation needed to be sent with the error correction forms the claims would generate. SC Medicaid is notorious for denying claims as untimely due to the documentation not being reviewed with the claims. Our office has lost thousands of dollars in past years after sending documentation repeatedly for the same claim for it to have to be written off as untimely, regardless of the office can provide proof of timely filing. If delivery claims need to be processed with the same procedure and there are no more trained staff members at Medicaid to process these claims quicker, there will be an increase in untimely denials that our office cannot continue to support.</p> <p>I went to Medicaid last week to meet with the appropriate person regarding these issues. Again; to date, these issues are still not resolved. It is very concerning that it is three and a half months after both of these new policies were enforced, and there is still no procedure in place to correct the problem.</p>	<p>Paula B. Hinton Office Manager Greenwood Center of Gynecology, LLC.</p> <p>Provider: J. Randall Erickson, M.D Practice Name: Greenwood Center of Gynecology, LLC.</p>	<p>email</p>
	<p>KeyPro. There continues to be some problem with the implementation of KeyPro as the prior authorization entity. Providers report that complying with KeyPro's information submission timelines is often difficult to execute and once in, response from KeyPro is sometimes slow. This creates a burden for providers in terms of the time and resources expended to comply and then can result in an additional financial to the hospice as they continue to provide the full range of hospice service while they await a determination from KeyPro.</p> <p>Recommendation: Encourage/require KeyPro to meeting with the hospice industry to share and address these concerns. Please note: The Carolinas Center has attempted but been unsuccessful in</p>	<p>Tamra West, Senior Director The Carolinas Center for Hospice and End of Life Care</p>	<p>email</p>

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	facilitating such a meeting through our contact with KeyPro.		
	ECFs require lots of manual work. Some of the ECFs generated are a result of system updates that have not been loaded. Recommendation: Medicaid should look at new technology and make more timely system updates or eliminate ECFs.	Susan Mills/Spartanburg Regional	Spartanburg Forum
	Very manual process to file EMS claims. Have to manually key entire claim through web tool. Clearinghouse requires certain documentation for 837i that isn't there. Recommendation: Match EDI requirements to web tool	Susan Mills/Spartanburg Regional	Spartanburg Forum
	Different requirements for Medicaid and Medicare claims processing. Recommendation: State should follow federal guidelines and mirror edit process	Susan Mills/Spartanburg Regional	Spartanburg Forum
	KePro gives multiple numbers and DHHS only accepts 1. Recommendation: Would like a program representative and increased training for provider service center.	Susan Mills/Spartanburg Regional	Spartanburg Forum
	KePro gives multiple numbers and DHHS only accepts 1. Recommendation: Would like a program representative and increased training for provider service center.	Denise Downey/SRMC	Spartanburg Forum
	Hard to get explanation of claim denial. Recommendation: Would like specific details on denials	Brice Elvington	Florence Forum
	Requirement to submit original paperwork when original paperwork is then scanned and trashed. Recommendation: Would like to submit scanned copies	Edna McClain (Hospice)	Florence Forum
Community Long Term Care			
New TCM Guidelines	Home visits would put a strain on our Department because it requires that two staff members go out on each visit. Many of our clients live in unsafe neighborhoods. Our staff is not equipped to make such trips, and we do not have sufficient staff to be able to send two staff members on each trip. Also, these trips are very time-consuming in general. Recommendation: Remove the requirement in the new TCM Guidelines to have an in home visit within 6 months before you are able to bill these codes	Sue Munn Deputy Director Clarendon Behavioral Health Services	email
Medicaid Nursing	The statute was originally passed in the mid-1980's in order to manage the growth of Medicaid skilled nursing home expenditures. Prior to its passage, the General Assembly enforced a CON moratorium	Thomas E. Brown, Jr, DrPH	Email

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<p>Home Permit Program; Proposed Statute: Proposed Medicaid Nursing Home Permit Revision Bill</p>	<p>on new skilled nursing facilities wishing to participate in Medicaid. The purpose of the moratorium was to enable the Medicaid Department to implement the Community Long Term Care (CLTC) program, a new home and community-based service alternative for individuals who qualified to skilled nursing facility admission under Medicaid and desire to age in place and receive their long term care services in their own home. This program started in 1984.</p> <p>Implementation of the permit day program effectively grandfathered in existing facilities and, over the last 25 years, has limited new skilled nursing facilities' ability to participate in the program. Additional criteria for participation, such as measures of quality of care, patient preference and purchasing value, and a contracting process that does not allow open enrollment for any willing provider and bidding have not been incorporated into the contracting process.</p> <p>The current system negatively impacts South Carolina's Medicaid population in several ways. First, introduction of quality measure in the contracting process would assure that the state and Medicaid eligible skilled nursing residents are receiving the highest value and quality of care for the Medicaid expenditures. Second, the current system requires skilled nursing resident who reside in a non-participating facility must re-locate to another facility when they outlive their resources and become Medicaid eligible for skilled nursing facility services. These transitions often are very detrimental to the residents' health and safety and adversely affect life expectancy.</p> <p>Recommendation: Alternative: Maintain the Current Law for FY 14 and Repeal in FY 15 The Medicaid Nursing Home Permit program has been successful in controlling the number of Medicaid eligible nursing home residents served each year. Changes (increases and decreases) in this number have occurred in accordance with the number of days authorized in the annual state budget. For example, in 1997 the average daily census of Medicaid skilled nursing facility residents was 11,160. Five years later in 2002, the number had increased to 12,154, and in 2012 the average daily census was 10,416.</p> <p>Over this same time period, the state's Medicaid policy goal was to increase access to home and community-based services for those individuals requiring long term care services. As a result, Community Long Term Care's average daily census has grown from 6,269 in 1997, to 11,011 in 2002 and to 12,106 in 2012.</p> <p>Another long term care system change which will significantly impact provision of the state's Medicaid long term care services will be implementation to the South Carolina Dually Eligible Demonstration Project – SC DuE. Under this project, beginning in the fall of 2013 approximately 65,000 non-institutionalized dually eligible individuals will be enrolled in managed care organizations (MCO) and will begin receiving all Medicare and Medicaid services through the MCO in January 2014. Ninety days of skilled nursing facility services and all CLTC services will be included in the</p>	<p>President and CEO Lutheran Homes of South Carolina</p>	

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	<p>benefit package and capitation payment rate. MCO's will have the ability to introduce appropriate criteria for selecting and contracting with skilled nursing facility and CLTC providers. As more Medicaid eligible South Carolinians age and become frail and disabled in the future, growing numbers of the MCO members will become eligible for long term care services.</p> <p>In addition to the increased availability of home and community-based services and implementation of the SC DuE project, dually eligible South Carolinians also have access to long term care services through the state's two Program of All-inclusive Care for the Elderly (PACE), which are located in Orangeburg, Richland and Lexington Counties.</p> <p>South Carolina's Medicaid nursing home permit program is unique among the nation's Medicaid programs. And, while it has been effective in the past, the permit program is not compatible with the changes in the health care financing and delivery systems and the state's Medicaid policy goal to increase the availability of alternative systems for accessing Medicaid-sponsored long term care services.</p> <p>Recommendation: FY 14 will be a year of transition for the Medicaid program. Lutheran Homes of South Carolina recommends that during this year a) the current Medicaid Nursing Home Permit program and statute remain unchanged and b) appropriate inter-Department and provider groups begin a collaborative process to develop recommended revisions to state long term care policy for consideration by the SC General Assembly in January 2014.</p> <p>Further, Lutheran Homes of South Carolina recommends repeal of the current Medicaid Nursing Home program statute for the state fiscal year effective July 1, 2014.</p>		
Medicaid Nursing Home Permit Program	<p>Recommendation: Impact of Statute: The statute was originally passed in the mid-1980's in order to manage the growth of Medicaid skilled nursing home expenditures. Prior to its passage, the General Assembly enforced a CON moratorium on new skilled nursing facilities wishing to participate in Medicaid. The purpose of the moratorium was to enable the Medicaid Department to implement the Community Long Term Care (CLTC) program, a new home and community-based service alternative for individuals who qualified to skilled nursing facility admission under Medicaid and desire to age in place and receive their long term care services in their own home. This program started in 1984. Implementation of the permit day program effectively grandfathered in existing facilities and, over the last 25 years, has limited new skilled nursing facilities' ability to participate in the program. Additional criteria for participation, such as measures of quality of care, and a contracting process that does not allow open enrollment for any willing provider and bidding have not been incorporated into the contracting process. The current system negatively impacts South Carolina's Medicaid population in several ways. First, introduction of quality measure in the contracting process would assure that the state and Medicaid eligible skilled nursing residents are receiving the highest value and quality of care for the Medicaid expenditures. Second, the current system requires skilled nursing resident who reside in a non-participating facility must re-locate to another facility when they outlive their resources</p>	Vickie L. Moody, CEO Leading Age South Carolina (formerly Aging Services of SC)	email

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	<p>and become Medicaid eligible for skilled nursing facility services. These transitions often are very detrimental to the residents' health and safety and adversely affect life expectancy.</p> <p>Alternative: Maintain the Current Law for FY 14 and Repeal in FY 15 The Medicaid Nursing Home Permit program has been successful in controlling the number of Medicaid eligible nursing home residents served each year. Changes (increases and decreases) in this number have occurred in accordance with the number of days authorized in the annual state budget. For example, in 1997 the average daily census of Medicaid skilled nursing facility residents was 11,160. Five years later in 2002, the number had increased to 12,154, and in 2012 the average daily census was 10,416. Over this same time period, the state's Medicaid policy goal was to increase access to home and community-based services for those individuals requiring long term care services. As a result, Community Long Term Care's average daily census has grown from 6,269 in 1997, to 11,011 in 2002 and to 12,106 in 2012. Another long term care system change which will significantly impact provision of the state's Medicaid long term care services will be implementation to the South Carolina Dually Eligible Demonstration Project – SC DuE. Under this project, beginning in the fall of 2013 approximately 65,000 non-institutionalized dually eligible individuals will be enrolled in managed care organizations (MCO) and will begin receiving their entire Medicare and Medicaid services through the MCO in January 2014. Ninety days of skilled nursing facility services and all CLTC services will be included in the benefit package and capitation payment rate. MCO's will have the ability to introduce appropriate criteria for selecting and contracting with skilled nursing facility and CLTC providers. As more Medicaid eligible South Carolinians age and become frail and disabled in the future, growing numbers of the MCO members will become eligible for long term care services. In addition to the increased availability of home and community-based services and implementation of the SC DuE project, dually eligible South Carolinians also have access to long term care services through the state's two Program of All-inclusive Care for the Elderly (PACE), which are located in Orangeburg, Richland and Lexington Counties. South Carolina's Medicaid nursing home permit program is unique among the nation's Medicaid programs. And, while it has been effective in the past, the permit program is not compatible with the changes in the health care financing and delivery systems and the state's Medicaid policy goal to increase the availability of alternative systems for accessing Medicaid-sponsored long term care services.</p> <p>Recommendation: FY 14 will be a year of transition for the Medicaid program. Leading Age SC recommends that during this year a) the current Medicaid Nursing Home Permit program and statute remain unchanged and b) appropriate inter-Department and provider groups begin a collaborative process to develop recommended revisions to state long term care policy for consideration by the SC General Assembly in January 2014. Further, Leading Age SC recommends repeal of the current Medicaid Nursing Home program statute for the state fiscal year beginning July 1, 2014.</p>		

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	Proposed Statute: SC Health Care Association's Proposed Medicaid Nursing Home Permit		
	CLTC doesn't know all of their policies. Recommendation: Need to have access to information in order to answer questions.	Rhonda Broom	Florence Forum
Dental			
	Dentaquest takes up to 3 weeks for authorization for hospital dental visits. Recommendation: Focus on dentists who don't follow rules. Don't make everything go through Dentaquest. Remove authorization.	Brice Elvington	Florence Forum
	Would like to treat patients on actual needs rather than limits by age requirements for dental services.	Brice Elvington	Florence Forum
	Many dentists are on precipice of dropping Medicaid	Brice Elvington	Florence Forum
	No follow-up from Dentaquest on potential improvements.	Brice Elvington	Florence Forum
Eligibility			
	Recommendation: SCDHHS should promulgate regulations about key provisions of Medicaid waivers, including eligibility criteria. Businesses that provide services through the waivers, as well as individuals, will benefit from being able to participate in the regulatory process. See for example Virginia regulation. See Vermont regulation.	Nancy C. McCormick, Attorney at Law Protection and Advocacy for People with Disabilities, Inc.	email
	Pendleton Place for Children and Families is concerned about the termination of Medicaid benefits for parents whose children have entered custody of South Carolina Department of Social Services. Our stance is that discontinuing Medicaid prevents the caregiver from following through on court ordered mental health or substance abuse counseling. Recommendation: Therefore, we recommend continuing parental or caregiver Medicaid benefits up to one year upon removal of a child or children. This will assist removing barriers for parent(s) not being able to access or afford court ordered treatment which impedes efforts made by all Child and Family Welfare Service entities across the state of South Carolina in regards to improving safety, well-being and reunification for children, Parents(s) and families, in general.	Laurie Roven Executive Director Pendleton Place for Children and Families	email

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	<p>We make it a policy at our office to never judge someone based on a sample pool of n=1. If someone on Medicaid has a \$40,000 car, we don't know how they got it (grandpa may have paid for it, they may have won it, they may have bought it before losing a job, they may rebuild cars, etc.). But we also keep up with trends. So when dozens and dozens of patients on Medicaid roll up in \$40,000+ vehicles, we know there is something terribly wrong with the algorithms in place for determining Medicaid eligibility. Apparently there are a lot of people that don't have the money for their "needs", but have plenty for their "wants". When speaking with colleagues that don't accept Medicaid any longer, but have at some point in their past, this is the most common justification we hear for never taking it again – "I got tired of seeing my patients rolling up in nicer cars than I drove (or could afford if they were a young dentist/doctor) to get their free work done".</p>	<p>Brice Elvington Florence Pediatric Dentistry</p>	<p>email</p>
	<p>We only have two ladies answering the phones at our office and they also check patients in and out, confirm appointments, run the front desk, and help out as needed in other areas. We are no longer accepting new patients with Medicaid insurance, but are still a provider for our current patients and those with special needs. They don't have the time to take all the calls we get wanting to schedule an appointment with Medicaid that find out about us from their case worker or provider list. There needs to be a more sophisticated list that specifies: accepting new patients, no longer accepting new patients, only taking patients under 6 years old, only accepting patients with special needs, etc. This would save time for employees at offices that accept Medicaid and be less of a hassle for parents looking for an office that is taking new patients. I am worried that if Medicaid is expanded to thousands more children, this problem will only become worse and will happen all at once, causing many offices to drop out completely.</p>	<p>Brice Elvington Florence Pediatric Dentistry</p>	<p>email</p>
	<p>There needs to be a second tier of Medicaid for those that make a certain amount of money or value good healthcare, but may have trouble paying full fees. It could be called Medicaid Premier and pay at a fee schedule 20-30% higher than the current one, but with 50% of the responsibility on the member. For those with Medicaid as secondary insurance, they may still not have to pay anything. This would be a win-win-win: patients pay a discounted rate on healthcare, Medicaid pays out 35-40% less on claims, and the providers receive 20-30% more on their EOBs. It would also free up more appointments in offices set up to take Medicaid as it currently stands and offices that don't currently accept Medicaid now may be open to accepting Medicaid Premier. It would also keep Medicaid from being an all or nothing program and more people on Medicaid would make it a goal to get off Medicaid without the worry of losing an insurance that pays everything or nothing.</p>	<p>Brice Elvington Florence Pediatric Dentistry</p>	<p>email</p>
	<p>Allow offices to require deposits to reschedule a broken appointment. You don't have to allow broken appointment penalty fees, but do allow a deposit to be required if the patient misses an appointment. Patients with a history of a broken appointment are far more likely to have another one than someone who hasn't. This is why many offices won't reschedule those without some type of commitment up front. Some may be willing to pay this deposit to avoid having to wait 6 months to get in at another office, and as long as they show up, they get it back.</p>	<p>Brice Elvington Florence Pediatric Dentistry</p>	<p>email</p>

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	Offer a second level of Medicaid with copay	Brice Elvington/	Florence Forum
General			
	<p>Administrative burdens on providers and vendors; providers are burdened by repetitive requests for similar information</p> <p>Recommendation: Create a Centralized Repository Vault.</p> <p>Current regulatory authorities or state agencies with compliance responsibilities impacting providers or vendors should pursue a <i>Centralized Repository Vault</i> or <i>Document Vault</i>. This is an electronic vault into which providers/vendors upload key documents that are most often requested by state licensing/monitoring entities. Once the documents are uploaded, state Department personnel are required to use the vault to review the provider's/vendor's Department information. The provider/vendor has the right to refuse copies or pull documents that are in the electronic vault.</p> <ul style="list-style-type: none"> • The vault can save administrative time and promotes efficiency. Agencies must assign personnel to upload documents and to assure that affected parties understand what has been “deposited” into the vault. Providers/vendors are required to assure all documents are current. • A centralized repository vault eliminates duplication of government services allowing providers to focus on direct provision of care. • Provider agencies must have assurances that budgets containing detailed salary information are protected, so the need to control access into the vault is essential. • The vault streamlines reporting to the state’s human service agencies and eliminates duplication of services, providing more efficient monitoring. Compliance or regulatory staff can review much of the important documents prior to on-site visitation, saving administrative time at the site. • Authorized personnel of community service providers that are currently under contract with a state human services Department have access to the vault. Service providers must register to receive authorization to use the system by visiting a designated state website. • The vault accepts and securely stores data using an easy-to-use web form to make entries and upload documents for review by state agencies. • Relevant data and documents from human service providers are collected at once and shared among these agencies, relieving providers of the administrative burden of repetitive requests for similar information. 	Paula M. Fendley, M.Ed., LMSW CEO Palmetto Association for Children & Families	email
	<p>Administrative burdens on providers and vendors</p> <p>Recommendation: Deemed Status</p> <p>There should be a <i>Deemed Committee</i> to address Deemed Status, an effort to “deem” certain licensing standards when an Department is accepted. Accreditation standards can be “cross walked” to certain state Department rules. Policy and legal personnel must review any rule changes and develop policy</p>	Paula M. Fendley, M.Ed., LMSW CEO Palmetto Association for Children & Families	email

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	guides/procedures for how deemed status would be consistently applied. Private sector members of the committee should provide input into those policy guides. Members of the <i>Deemed Committee</i> should monitor the outcome of the deemed status process during license renewals. The committee must determine whether there is merit to the time investment needed to review crosswalks for CARF and JCAHO, as most may be accredited by COA.		
	Model BOI after what midwives are doing.	Tim Bethe/	Spartanburg Forum
	Natural birth saves money.	Irina Murzegildin	Spartanburg Forum
	Department suffers in contracting out as customer service slips Recommendation: Acknowledge the concern	Keith Randolph	Florence Forum
	No attention to ACA impact on providers	Keith Randolph	Florence Forum
	Broken appointments are much higher in Medicaid population. Recommendation: Accountability for beneficiaries	Brice Elvington	Florence Forum
Hospice			
DHHS 149 Form, DHHS 151 form	<p>Ø The whole hardcopy/paperwork-process regarding the Medicaid Hospice forms needs to be revamped. The Medicaid Hospice Benefit is supposed to “mirror” the Medicare Hospice Benefit, yet the process of Notice of Elections, Discharges, etc. is so much more cumbersome with Medicaid than with Medicare. Medicare allows each hospice to develop its own forms. For example, we have created our own Hospice Medicare Benefit Election Statement which would correspond to the DHHS 149 Form; we have our own Physician Certification/Recertification form which would correspond to the DHHS 151 form.</p> <p>Recommendation: To notify Medicare of a patient’s Hospice Medicare Election, we simply submit an electronic form, bill type 81A, for our Department. There are no hardcopy forms that we are required to send to Medicare. They are simply part of the patient’s medical record/chart. The Medicaid Hospice Benefit should follow suit – so that it truly “mirrors” the Medicare Benefit. Surely, the SCDHHS Web Tool could be modified to accommodate and accept an electronic version of the Election form. If a patient is “Medicaid-only”, i.e. not Medicare/Medicaid-dual, the process is even worse as everything has to go through KEPRO; there is even more paperwork – and again, it’s all hardcopy.</p>	Jan Burton Reimbursement Coordinator HospiceCare of the Piedmont, Inc.	email

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	<p>The South Carolina Home Care & Hospice Association, a 34-year old association representing home health, hospice, and personal care/private duty home care agencies across the state, appreciates the opportunity to comment on existing regulations. Our home care agencies that provide services under the Community Long Term Care Waivers have outlined the following areas for your consideration. There is an unwritten policy in place that home care aide staff members using the Care Call system are allotted 6 “strikes.” Many of these strikes are for issues that are beyond the control of the staff and Department. One example is when Department staff members are not able to check-in at the client’s home because the client does not have a functioning phone and the case manager is not notified within 48 hours of the service event. The resolution procedure for these strikes is implemented inconsistently across case managers. In some cases, clients have not had functioning phone for long periods of time, yet strikes are assigned for lack of notification. We believe that the “strike” practice of not submitting for claim, what would otherwise be a valid service provision, is not appropriate.</p> <p>Recommendation: We request that procedures be clarified and standardized, including the definition of a “strike” and how issues can be resolved or eliminated.</p>	<p>Heather P. Jones, MPH, CHES, COS-C Director of Quality Initiatives & State Liaison South Carolina Home Care & Hospice Association Association for Home & Hospice Care of North Carolina</p>	<p>email</p>
	<p>Another area of concern is the requirement for having to conduct aide supervisory visits on admission, again within 30 days, and then every 4 months. Additionally, supervisory visits are required after client hospital stays. This requirement is more strenuous than found in many other states. The requirement for supervisory visits within the first 30 days is especially problematic for agencies.</p> <p>Recommendation: We request that SCDHHS reflect on this requirement to see if there is an opportunity for flexibility in the frequencies for these visits, allowing administrative staff to conduct the visits, or allowing some supervision to be conducted as a phone call with the client. As a reminder, the Nurse Supervisors provide no hands on care and are not providing skilled home health services.</p>	<p>Heather P. Jones, MPH, CHES, COS-C Director of Quality Initiatives & State Liaison South Carolina Home Care & Hospice Association Association for Home & Hospice Care of North Carolina</p>	<p>email</p>
	<p>Hospice/Facility Room and Board Pass Through: Process is cumbersome for both provider groups and there is high risk for error by both provider groups. The hospice maintains the bulk of the financial risk if rates are miscalculated and adjustment in reimbursement is necessary. While there has been some report by nursing facilities regarding timely payment of the R&B rate by the hospice, hospices have also had difficulty recouping any overpayment they may have made to the nursing facility.</p> <p>Recommendation: We recognize this is a CMS requirement and only one or two other states are not utilizing the R&B pass through payment process. Would it possible to seek a waiver of this from CMS? In addition to the burden on providers, this continues to be an administrative challenge for DHHS. With the apparent dissolution of specific program area staff positions, this will become an</p>	<p>Tamra West, Senior Director The Carolinas Center for Hospice and End of Life Care</p>	<p>email</p>

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	<p>more difficult process for providers and the burden of questions and resolution will fall to the Customer Service Center and staff there do not appear to be sufficiently prepared to assist providers in navigating and resolving the issues that arise from this process.</p>		
	<p>CLTC/Hospice Overlap</p> <ul style="list-style-type: none"> • Current structure of hospice/CLTC program overlap creates an inherent deterrent/limit to access of hospice to Medicaid beneficiaries. For example, a patient receiving a number of hours per day of in-home, non-skilled support through CLTC cannot elect hospice without giving up that service. Patients and families are most often reluctant to give up a service/provider they are comfortable with even if hospice provides them with a wider array of services. This is certainly a burden to patients and families that would otherwise desire and benefit from election of hospice services. It creates a burden for hospice providers that may expend time and resources preparing for admitting patients that are then identified as receiving these services and thereby not eligible to elect hospice. This is also a financial burden to the state as the more folks enrolled in hospice, the more efficiently healthcare dollars are expended. <p>Recommendation: Look at other states to see how they have implemented their community based waiver programs such that they are compliant with CMS requirements to avoid “double-dipping” and limiting the negative impact of the program’s structure. Work with the hospice and CLTC providers to implement any changes that may be allowed by CMS.</p>	<p>Tamra West, Senior Director The Carolinas Center for Hospice and End of Life Care</p>	<p>email</p>
<p>General Medicaid Policies/Procedures</p>	<p>Medicaid has created a required set of documents (election, certification, discharge, revocation, etc. forms) that contain the same required information as the hospice agencies’ own forms which are required to meet strict guidelines set forth by CMS for Medicare hospice beneficiaries. While Medicaid hospice patients are typically a very small percentage (less than 5%) of the total patients, having to complete and submit separate reports is a burden for providers. There is also timeliness of submission requirements for Medicaid hospice beneficiaries that vary slightly from those same requirements for Medicare hospice patients. This creates an undue burden on providers’ internal processes and can result in errors that can result in delay in start of care, result in payment delays/error. This requires dually-eligible patients to sign two sets of forms for the same care which creates a burden for them at a very vulnerable and stressful time.</p> <p>Recommendation: DHHS work with the hospice industry to evaluate the processes and forms in the current Hospice Provider Manual and revise accordingly to eliminate burdens to patients/families, hospice providers and the state.</p>	<p>Tamra West, Senior Director The Carolinas Center for Hospice and End of Life Care</p>	<p>email</p>
	<p>3rd party to approve hospice. Provider service center is not helpful.</p> <p>Recommendation: Would like provide representative for escalation.</p>	<p>Edna McClain</p>	<p>Florence Forum</p>

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	<p>Hospice-choose between CLTC and hospice. Want to help patient to stay at home, but end up choosing CLTC and don't get hospice benefit.</p> <p>Recommendation: Combine resources from CLTC and hospice (can do for under 21)</p>	Edna McClain	Florence Forum
	<p>Frugal treatment during vegetative state. Provider needs to educate on options.</p> <p>Recommendation: require providers to educate about choices, compensation</p>	Edna McClain	Florence Forum
Managed Care			
MCO requirements for Substance Abuse	<p>The new MCO prior authorization process has also added a tremendous burden to our Department in terms of administrative work required in delivery of services to our clients. This process requires more staff hours devoted to obtaining this prior authorization and yet the turnaround time for reimbursement is much slower.</p> <p>Recommendation: Remove the requirement for PA on Outpatient Services</p>	Sue Munn Deputy Director Clarendon Behavioral Health Services	email
1932(b)7 SSA	<p>1932(b)7 of the SSA With elimination of Medical Homes Network, unable to contract with MCOs.</p> <p>Recommendation: Would like to bill under FFS or carve-in to MCO</p>	Brandy Brandfass/ Licensed midwife Charleston Midwife/ President of Midwife Association	Charleston forum
	<p>MCO programs required different billing codes.</p> <p>Recommendation: Unified billing codes</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers	Charleston forum
	<p>Medicaid uses nurse midwife rather licensed midwife then MCO reimburse for licensed midwife rather than certified nurse midwife.</p> <p>Recommendation: Need separate codes for billing purposes and/or additional modifiers.</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers	Charleston forum

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Medicaid Managed Care Retro-enrollment	<p>Require Medicaid managed care plans to apply timely filing to cases involving retroactive coverage resulting in expensive appeals and denials.</p> <ul style="list-style-type: none"> · SC DHHS has not mandated a process for the managed care plans to properly process coverage for those members who are approved retroactively and choose participation in an HMO plan (specifically, moms, newborns and babies). Therefore, many times retro-coverage is granted and an HMO is selected yet the affected visits are outside of the timely contractual for the managed care plan as they do not follow the traditional Medicaid timely limit. As a result, these retro claims deny and then must be appealed to be reconsidered. This is unnecessary costs for both the provider and the state in both money and time. · SC hospitals currently serve prospective Medicaid clients before they have submitted an application to the Medicaid program or during the span when their application is in pending status. These patients are expectant mothers, neonates and children. We treat them regardless of their ability to pay or the status of their application. This segment of our SC population is often the most critically in need of care and assistance to insure healthy starts for South Carolina's youngest and most precious resource. However, when retroactive coverage is deemed appropriate, their selection of a managed care plan could mean their retroactively covered visits will not be processed. Managed care companies are hiding behind contractual timely filing guidelines instead of reimbursing for these visits. The hospital is told the only recourse is to accept the denial and then appeal the claims to receive reimbursement that should 	James R. Walker, Jr. Senior Vice President, Regulatory and Workforce South Carolina Hospital Association	email; hand- delivered
	<p>Problem: Licensed Midwives are unable to be authorized providers in MCOs as the practice partner agreements currently exist. The DHHS decision to eliminate the Medical Homes Networks (MHNs) by the end of the year will effectively eliminate Licensed Midwives as a provider option to eligible women.</p> <ul style="list-style-type: none"> • In the SC DHHS Provider Manual, Updated 4/1/2013, Licensed Midwives are referenced in Section 2, Page 4, and have been eligible providers since 1994. • Section 1932(b)(7) of the Social Security Act reads: “(7) Antidiscrimination.—A Medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification. Therefore, the MCOs in South Carolina are in violation of the federal SSA statute by disallowing LMs from being authorized providers within their structures. • When women are initially deemed eligible for Optional Coverage For Women And Infants, they are initially covered under the Fee-For Service option for the first **30** days. After this time, women are forced to choose an MCO or MHN, or will be randomly assigned to one. • Without the Medicaid income from women who have opted for a MHN, specifically SC Solutions, the potential closure of several of the 5 LM-owned and operated birth centers is very real. This would affect over a dozen LMs who currently attend deliveries in birth centers, and the LMs who accept 	Brandy Brandfass, RN, LM, CPM President, South Carolina Licensed Midwives Association	email

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	<p>Medicaid for home birth.</p> <ul style="list-style-type: none"> • LMs have enjoyed ease of billing and reimbursement with the FFS option. <p>Recommendation: Maintain the Fee-for-Service Option for all women who opt to receive care from Licensed Midwives. Do not force a woman who has chosen to begin her prenatal care with an LM to select an MCO. If a woman decides to switch to a Licensed Midwife after the onset of care with any other provider, grant her rapid transition to the FFS option so no lapse in prenatal care occurs.</p>		
	<p>Do not know when new MCOs come into area.</p> <p>Recommendation: MCO updates should be posted on the website and sent out via bulletin notification</p>	Katina Jones/Carolina Family Services of Greenville	Spartanburg Forum
	<p>Was told FFS would never go away. Moms are burdened by choosing</p> <p>Recommendation: Keep FFS. It is simple and straightforward.</p>	Linda Weomer/ Labors of Love Birth Center	Spartanburg Forum
MCO Contract 1.4 12.4	<p>The South Carolina Department of Health and Human Services (the Department) has consistently informed the Health Plans (the Plans) that MCO policy and procedure will be relayed to the Plans either through the two guiding documents - the MCO Contract and the MCO Policy & Procedure Guide - or by way of a Medicaid Bulletin. The Plans were instructed to rely solely on those three documents for guidance on MCO policy and procedure. While the Department does use these means of relaying policy and procedure, the Department also relays changes to policy and procedure through letter, email and/or comments made in meetings, and with no formal follow-up to substantiate the change. This creates a conflict between the Department's new expectations and the current policy and procedure as outlined in the guiding documents. This also leads to lack of clarity on the part of the Plans as to how to proceed and necessitates constant requests to the Department for clarification, which is rarely provided through the proper methods outlined above. This method of notification often puts the Plans in the position of having little if any time to make the administrative and system changes necessary to implement the change, resulting in undue and unnecessary administrative burden on the Plans.</p> <p>Recommendation: The Department should follow its established procedure of providing notification to the Plans of changes to policy and procedure only through the official channels - the MCO Contract, the Policy and Procedure Guide and/or a Medicaid Bulletin. The Department should also provide sufficient notice of upcoming change to Policy and Procedure so the Plans have sufficient time to provide input and make any administrative and system changes necessary to implement the change.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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MCO Contract 3.6	<p>This policy potentially penalizes the Plans for changes required by the Department or for federally required changes.</p> <p>Recommendation: We recommend that the Department change this Section to read: "The Contractor shall be charged for any Plan initiated changes to its network, website, mailings, Contractor specific services or any other change that requires any alteration or modification of the Department's information provided to Medicaid MCO Members or Providers related to this Contract. For Plan initiated changes, the Department will provide the Plan an estimate of the required change. Any cost over and above the estimate must be approved by the Plan prior to the work being concluded."</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 13.45 P&P Guide 13.0	<p>Federal regulations require state Medicaid agencies to verify that each Medicaid provider has not been excluded from participating in federal health care programs. The Department has delegated this responsibility to the Plans. As a result, since the great majority of providers are enrolled in most if not all of the MCO networks, each of the Plans ends up checking the same providers against the federal and state exclusion databases each month.</p> <p>Recommendation: The Department should move vigorously toward developing a centralized in-house regulatory-compliant process to periodically check all participating providers against state and federal exclusion databases. This would eliminate the administrative burden and costly duplication of effort imposed upon the providers and Plans by the current process. Alternatively, the Plans should be permitted to utilize the Department's exclusion checks for any Medicaid participating provider that is in the Plan's network.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 4.9	<p>This provision discourages innovation in delivery of care and places the Plans at an unknown risk since there is no requirement for estimate and approval of additional costs.</p> <p>Recommendation: We recommend that the Department add the following to the end of the first paragraph in Section 4.9: "For Plan initiated changes, the Department will provide the Plan an estimate of the cost involved. Any cost over and above the estimate must be approved by the Plan prior to the work being concluded."</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 4.12.2	<p>There are circumstances in which a Plan could lose a vital provider in a geographic area resulting in network inadequacy. In this event, the Plan may be required to decertify that county until it can resolve the inadequacy. Having to terminate all existing Provider contracts within the county makes the recertification process inordinately difficult and imposes significant burden on the provider community.</p> <p>Recommendation: We recommend that this requirement be deleted as it serves no constructive purpose.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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MCO Contract 4.12.2	<p>In this scenario, the Plan's network has already been approved by the Department. Therefore, if there is no material change to the Plan's network then there is no legitimate basis for terminating the county in question.</p> <p>Recommendation: We recommend that the phrase "whether or not a material change in the Contractor's network has occurred" be deleted from this paragraph.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 4.12.2	<p>The Plans currently provide the Department with a listing of network providers each month from which the Department can determine any additions and deletions from the network. This new requirement would have the Plans obtain preapproval by the Department for any increase or decrease in the provider network regardless of its impact on network adequacy. This is not the way network development functions as Providers are added and deleted every day. This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to potentially subject the Plans to punitive action on the part of the Department.</p> <p>Recommendation: We recommend that the words "are not prior approved by the Department and/or" be deleted from this section.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 7	<p>This language is inaccurate as the Plans are allowed to market to Medicaid-eligible individuals as governed by subsequent guidance on marketing requirements outlined in the MCO Contract. Therefore, this sentence is in direct conflict with the subsequent guidance.</p> <p>Recommendation: We recommend that this sentence be deleted from Section 7 of the MCO Contract.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 7.1, 8.3.1, 8.4 P&P Guide 14.3	<p>This is one of several instances of conflicting information in the guiding documents provided by the state that impose the burden on the Plans to continually seek clarification, which impedes the proper administration of the Medicaid MCO program.</p> <p>Recommendation: We recommend that the references in the MCO Contract be changed to indicate member materials should be written at no higher than a seventh grade level to be consistent with the P&P Guide.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 9 9.1.2.1.2 9.1.2.2.1	<p>The first section (9.1.2.1.2) matches verbatim the federal language at 42CFR438.402(b)(ii). The second section (9.1.2.2.1) conflicts with the first and therefore conflicts with the Code of Federal Regulations. In response to a request from the Plans for clarification, the state responded that the member's written consent will not be required from the member's physician, and utilizing it against current contract language could result in sanctions to the Plan. This conflicting guidance poses significant risk for the Plans in that compliance with 9.1.2.1.2 as written puts the Plans at risk for sanction by the state, whereas compliance with 9.1.2.2.1 puts the Plans out of compliance with federal regulations.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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	<p>Recommendation: We recommend that the Department resolve this conflict by deleting from 9.1.2.2.1 the sentence that says, "During the Contractor's Appeal process neither the Medicaid MCO Member nor the Provider who is acting on behalf of the Medicaid MCO Member is required to provide a written authorization."</p>		
MCO Contract 10.16	<p>This is a tremendous waste of time and effort for the Plans and the Department that provides no programmatic benefit. If the Department has approved a document and the document has not changed in any way, there is no purpose served by submitting it to the Department each year. Additionally, every plan undergoes an annual External Quality Review process in which every one of the Required Submissions documents is reviewed for compliance with state policy and procedure. Therefore, it seems unnecessary and excessive to require the Plans to send the same documents to the Department each year for no apparent purpose.</p> <p>Recommendation: We recommend that the Department delete this requirement and rely on the External Quality Review process to conduct the document review that it is designed and intended to provide.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 11.4 P&P Guide Appendix 6	<p>11.4 Auto-Assignment Algorithm: "The Department shall update the managed care auto-assignment algorithm to direct beneficiaries to managed care health Plans that have higher quality and performance measures, as reasonably determined by the Department or its designee."</p> <p>P&P Guide Appendix 6 - Quality Weighted Auto Assignments: "New health Plans will receive member assignments based on the Quality Weighted Assignment Factor for a three star health Plan. Once the new health Plan receives a rating, assignments will be based on that value at the start of the next period."</p> <p>Recommendation: We recommend that the provision in Appendix 6 be changed to state that members are assigned to a new Plan based upon the baseline "two star" assignment factor, thereby eliminating the unfair advantage created by the current arbitrary "three star" assignment factor.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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MCO Contract 12.7	<p>"Provider manuals" was added to this section of the MCO Contract without notice to the Plans. The Department has always defined Marketing as "Any communication approved by SCDHHS from an MCO to an existing or potential Medicaid Recipient that can be interpreted as intended to influence the Recipient to enroll in that particular MCO Medicaid product..." The provider manual is not a tool for marketing to potential or existing member and therefore is not considered a Marketing Material and, per the Department's definition of Marketing, should not be subject to review. When we asked the Department if it was changing its definitions of Marketing and Marketing Materials, the response was that they are not changing the definition of marketing materials but simply expanding their requirements for review to include provider and other materials. This is a perfunctory change made by the Department without consideration of the administrative burden it imposed on the Plans. It is also another example of the Department's failure to follow its procedures to properly notify the Plans of policy changes.</p> <p>Recommendation: We recommend that the reference to "provider manuals" be deleted from this section.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 13.2.9.18	<p>The Contractor (Plan) has no control over who is performing the work and at what price but yet is held financially responsible for the costs involved.</p> <p>Recommendation: We recommend that this section be deleted or at least changed to stipulate that the Contractor will be apprised of the costs associated with the termination and allowed to determine that the costs being incurred are reasonable and equitable.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
MCO Contract 13.3	<p>This section relates to the process in which incentives are paid to the Plan for meeting performance goals and the Plan then passes on a portion to the appropriate provider(s). There are two arguments against requiring the Plan, even a terminating one, to refund incentive money: First, an incentive is earned based upon past performance. Therefore, there is no justification for requiring earned payment to be returned. Second, by extension if the Plan has passed part of its incentive payment on to a provider in a manner prescribed by the Department, there is no justification for requiring that portion of its earned payment to be returned either. This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to subject the Plans to punitive action by the Department.</p> <p>Recommendation: We recommend that the second paragraph of this section be deleted.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
221 MCO Contract 13.4	<p>In the event of an appeal decision being overturned in favor of the Plan, it is neither reasonable nor equitable for the Department to charge the Plan for costs the Department incurs in the unsuccessful defense of its own action. This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to subject the Plans to punitive action by the Department.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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	<p>Recommendation: We recommend that the phrase "less any cost incurred by the Department" be deleted from this paragraph.</p>		
222 P&P Guide 2.6	<p>We would note that Section 2.7 - New Boilerplate Subcontract says, "Article I encompasses all SCDHHS required language." This reflects the fact that the Department developed standardized contract language that must appear as Article I in every provider contract to ensure that each contract addresses mandatory federal and state requirements. Ensuring the presence of this language also relieves the state from having to review every provider contract for every Plan to ensure those requirements are addressed. The Plans were informed that once Article I was in all provider contracts, the Plans were free to modify the remaining terms of the contract to fit their needs and did not have to send new or revised the contracts to the state for review and approval. It is our belief that Section 2.6 contains language that is outdated and obsolete now that the Plans have included Article I in all provider contracts.</p> <p>Recommendation: We recommend that the Department revise this Section by deleting the obsolete language.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
223 P&P Guide 2.9	<p>First, we would refer to our comments related to Section 2.6 above and the fact that the presence of Article I in provider contracts relieved the Plans from having to submit any revisions to the balance of the contract to the Department for review. Second, we would note that Section 8.0 of the P&P Guide says, "The relationship between the MCO and the provider is governed entirely by the contract between the parties. In this contract the provider agrees to accept Medicaid Members and the MCO agrees to pay for the provision of services as outlined in the contract. Thus, the issue of payment to the provider by the MCO is an issue between the two parties. SCDHHS is not a party to this agreement and will not exercise its authority to enforce the provisions of the contract between the MCO and the provider." Since the Department took steps to relieve itself and the Plans from the administrative burden of state review of amendments to provider contracts, and since the Department states it will neither review nor enforce the provisions of the Plans' contracts with providers, it is difficult to understand why the Department would choose to include new language that recreates the very administrative burdens it sought to eliminate in the first place.</p> <p>Recommendation: We recommend that the Department revise this Section by deleting the second paragraph.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
224 P&P Guide 4.2	<p>Previous versions of the P&P Guide state that for Providers who serve both the commercial and Medicaid populations, an identifiable separate page of the Credentialing Committee minutes that separately addresses each Medicaid provider being considered is acceptable documentation of the Medicaid Credentialing process. These new guidelines are excessive and administratively burdensome. We would also note that all Plans are now required to be accredited by NCQA, a process that includes stringent Credentialing requirements. Therefore, the new guidelines are unnecessary and</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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	<p>do nothing to enhance the Credentialing process. This is an arbitrary, capricious and unnecessarily burdensome change that serves no programmatic purpose other than to subject the Plans to punitive action by the Department.</p> <p>Recommendation: We recommend that the Department retract these requirements and reinstate the previous guidance.</p>		
225 P&P Guide 4.2	<p>42 CFR455.104 (c) says Medicaid agencies must require providers to provide disclosures of ownership: 1) at application/execution of the agreement; 2) upon request of the Medicaid Department during the re-validation of enrollment process [at least every 5 years]; and 3) within 35 days after a change of ownership status. The Department has indicated that the disclosure of ownership is an integral part of the recredentialing process but we can find no regulation to that effect. Therefore, we believe the requirement to obtain disclosure of ownership at recredentialing (every three years) is an arbitrary schedule unsupported by federal regulation. Providers readily understand the need for disclosure of ownership at contracting (which occurs every 5 years) and at such time as their status may change, but they are resistant to what they see as an arbitrary periodicity of “every three years” when there is no apparent regulatory requirement. The process of obtaining disclosures of ownership more frequently than at contracting is unwarranted and administratively burdensome for providers and Plans alike.</p> <p>Recommendation: We recommend that the Department revise its policy to state that Plans must obtain disclosures of ownership from providers at initial contracting and at least every 5 years thereafter during the recontracting process.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
226 P&P Guide 16.0 -	<p>Federal regulations require state Medicaid agencies to obtain Disclosures of Ownership from Medicaid providers at application and periodically thereafter. The Department has delegated this responsibility to the Plans. As a result, each provider who participates with more than one Plan must provide a separate Disclosure of Ownership Form to each Plan it is contracted with. This creates unnecessarily burdensome duplication of effort for participating providers who serve the state's Medicaid population.</p> <p>Recommendation: The Department should move vigorously toward developing a centralized in-house regulatory-compliant process to periodically obtain Disclosures of Ownership from all participating providers. This would eliminate the administrative burden and costly duplication of effort imposed upon the providers and Plans by the current process.</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email
227 SCDHHS Physicians Provider Manual	<p>The Department's guidance indicates that G0431 is the proper code to use when providers bill for drug screening. However, the National Healthcare Common Procedure Coding System (HCPCS) has been revised to recognize G0434 as the proper code to use when providers bill for drug screening. This is recognition of the fact that very few professional providers possess the necessary equipment for the tests that would be properly reported using the G0431 code, and rarely is there a medical need for the</p>	Sandy Wright Compliance Manager BlueChoice HealthPlan	email

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Section 2 - Alcohol and Drug Testing Policy	<p>type of testing indicated by G0431. The Department has failed to update its fee schedule to recognize this new coding. As a result, providers who bill for drug screening testing under the proper code of G0434 receive no reimbursement because that code does not appear on the state's fee schedule. The out-of-date fee schedule forces providers to billing using G0431 to get paid. Not only is this code inappropriate for the service provided, but it is also reimbursed at a rate that is significantly higher than the proper code of G0434, which improperly and unnecessarily increases the cost of service delivery for the Plans and the state. Additionally, the fact that the Department's failure to keep its fee schedule current forces providers to bill improperly to get paid subjects these providers to revenue recovery operations initiated by the Plans' Program Integrity units and to potential sanctions from federal agencies for the submission of false claims.</p> <p>Recommendation: We strongly recommend that the Department frequently monitor for changes to national coding standards on a regular periodic basis and promptly update its fee schedule accordingly. Alternatively, the Plans should be permitted to utilize the Department's exclusion checks for any Medicaid participating provider that is in the Plan's network.</p>		
Other State Agency			
Reg. 61-84; Section 801.C.5	<p>In general DHEC's incredible demands for documentation and multitudinous tasks are unwieldy. The volume of paperwork has, by my estimation, gone up 16 fold since 1993. I derive this by measuring the amount of shelf space now required vs. my last active time as an assisted living administrator. Crude but effective! (By the way I think this is the result of the "Reduction in Paperwork Act!")</p> <p>After having attended a DHEC Board meeting in Columbia on October 14, 2010 it was very evident that those proposing the new regulations had barely considered the true cost of implementation. At the meeting were numerous AL home operators who ran Medicaid approved facilities. I also spoke on their behalf. Private pay homes can try to pass such increases on to their residents. But Medicaid homes don't stand a chance. They have had so little reimbursement increase in the last fifteen years that I do not know how they can possibly comply with the existing demands, let alone...</p> <p>Ashlan Village spends more than half of our administrative time trying to stay abreast of, and ahead of the DHEC regulations. I estimate that for us this cost is between \$70,000 and \$85,000 annually. This directly strips time away from direct resident contact and care! I realize legal cases, etc. require good record keeping in order to protect residents and long term providers. (Apparently Tort reform is needed here also.) However, as a result I foresee Medicaid facilities dropping off of or under the radar and private pay homes pulling in their partial offer of Medicaid beds (which we provide and might be tempted to do). Some homes will be tempted to go without licensure!</p>	Robert Aho Administrator	email
Reg. 61-84; Section 801.C.5	<p>I am grieved by the inflexibility of "appropriate placement" the term DHEC uses when deciding if a person should be in Assisted Living (AL) or in a Skilled Nursing Unit (SNU). [Reg. 61-84; Section 801.C.5] Their ruling (which I suspect is due to the strength of the nursing home lobby) is that any person not able to do at least one Activity of Daily Living (ADL: eating, dressing, bathing, grooming</p>	Robert Aho Administrator	email

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	<p>and toileting) is automatically assigned to an SNU. My contention is that none of these ADL's necessarily require the cost or expertise of skilled nursing care. On a case by case basis the determination should be made, namely: "Is the less costly AL an appropriate housing option?" Admittedly many ALs do not want to deal with that level of care, but several of us have tailored our staffing abilities to provide this care. We do so, frankly, to help limit the number of moves the elderly have to make. Too often in the last season of life they are hopping around; first from their homestead to one of their family members or to an AL, then maybe to an SNU, and perhaps even to a Hospice house. In between most probably are hospitalizations. This requires a lot of adjustment and often grief for the senior and their families. Instead of this, by having hospice and home health come to the AL to assist, nearly 80% of the time we at Ashlan have been able to eliminate the last two moves for the families, thus providing much less hassle, less cost, and much more peace. Aggressive, inflexible enforcement of DHEC's "appropriate placement" rule will cut that percentage greatly, ensuring more late life hopscotch.</p>		
	<p>Related to the above are individual cases. Very recently we had to ship a resident to an SNU for this very reason. She was able to privately pay for her stay here but will now have to rely on state Medicaid or other assistance in order to stay at the SNU. Her care was very good, so much so that her P.O.A. and family were very distraught with the incredible demand that she be moved. In cases like these we and other homes face large fines if we delay, trying to help the families. The nature of long term ministry is to care for and about people. Relationship is the most significant factor while providing needed services. Bouncing people should be done only when absolutely necessary.</p>	Robert Aho Administrator	email
Reg. 61-84 Section 801.E.	<p>We were fined \$10,000 for keeping one person beyond the ADL limit. [Reg. 61-84 Section 801.E.] According to protocol I sent a "30 Day Notice" to the family. (The "30 Day" is our notice that the resident must be transferred to an SNU.) However, I did not know that I had to send out subsequent "30 Day notices" if the resident had not yet moved. Nowhere is this written in DHEC rules but they interpret the 30 Day ruling as automatically implying the necessity of additional notices and they expected me to "get it"! A bit of a heavy penalty for a rule that does not have clear interpretative resonance.</p>	Robert Aho Administrator	email

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	<p>The people of South Carolina formed DHEC to insure that proper, healthful care is provided for its citizens. We at Ashlan take our role in this process very seriously. We want to respect the desire of South Carolinians to know that good care is going on, instead of “nursing home exposes.” My role at Ashlan is to assure the public and DHEC that we are serious about good care and see to it that we provide it. We are not trying to circumvent DHEC rulings as if “thumbing our noses.” We want to comply because we know that the rules protect us and all citizens.</p> <p>But, speaking of the law the scripture says: “The letter of the law kills, but the spirit gives life.”</p> <p>South Carolina has compassion for its citizens because of its foundation on the principles of that book. The legislature of the state formed DHEC as a compassionate system of control and the spirit of that law was to always seek to provide the best in all situations. When the letter of the law and its rules trumps the wellbeing of one of its citizens something is wrong!</p> <p>If you need people to present to oversight committees, etc. I would be very willing to supply written and/or verbal testimony. If there are areas of concern from other homes it would be of interest to me to see their concerns. We might be able to chime in with additional comments.</p> <p>Thank you for your concern, your offer and for effective leadership. We appreciate it! Let me know if I can help in any way.</p>	Robert Aho Administrator	email
R. 126-910 through 940; R. 114-1910 through 1930	<p>DSS no longer administers the OSS program; DHHS has regulations, R. 126-910 through 940, governing OSS.</p> <p>Recommendation: SCDHHS should coordinate with DSS about regulations regarding the Optional State Supplement (OSS) program. DSS R.11401910 through 1930, Establishing for Optional Supplementation, and other references contained in Chapter 114 should be repealed.</p>	Nancy C. McCormick, Attorney at Law Protection and Advocacy for People with Disabilities, Inc.	email
Policy			
	<p>Freestanding Birth Center policies are under licensed midwife policies.</p> <p>Recommendation: Need separate policies as anyone can own a birth center.</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers	Charleston forum
	<p>Recommendation: SCDHHS should promulgate regulations for the composition and role of the Medical Care Advisory Committee, including a provision for public participation at its meetings</p>	Nancy C. McCormick, Attorney at Law Protection and Advocacy for People	email

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		with Disabilities, Inc.	
	<p>Medicaid billing manual hasn't been updated recently. Have to search bulletins for update that are not in manual</p> <p>Recommendation: Update manual timely</p>	Susan Mills/Spartanburg Regional	Spartanburg Forum
	<p>Lack of communication or program changes</p> <p>Recommendation: Increase communication of changes</p>	Katina Jones/Carolina Family Services of Greenville	Spartanburg Forum
	<p>Need PCP to complete referral form for treatment. Requires beneficiary to make 2nd trip.</p> <p>Recommendation: Eliminate form</p>	Tracey Redfearn/Child and Family Resource center	Florence Forum
	<p>Policy changes are only known when visiting website</p> <p>Recommendation: Push out information via listserv updates.</p>	Keith Randolph	Florence Forum
	<p>Manual references licensure requirements, which are outside of SCDHHS "ownership".</p> <p>Recommendation: Make clearer policies and eliminate references to other requirements</p>	Martha Kelly	Florence Forum
Provider Enrollment			
	<p>To enroll with Medicaid, must apply online with precepting physician.</p> <p>Recommendation: Precepting physician would be needed at time of claiming, but not required during enrollment.</p>	Joann Gottschall/ Birth Wife Midwifery Care	Charleston forum
	<p>No ability to enroll as licensed midwife. Must enroll as a certified nurse midwife.</p> <p>Recommendation: Create category for licensed midwife.</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers	Charleston forum
Provider Requirements			
Private Rehabilitative Therapy and Audiological Services manual	<p>In the recent past, SCSHA board members met with HHS personnel regarding the timeline discrepancy across service providers with regards to completing and signing clinical service notes. Currently, speech-language pathologists in private practice follow the guidelines in the Private Rehabilitative Therapy and Audiological Services manual. The guidelines state that clinical service notes "must be made by the provider delivering the service and should be accurate, complete and recorded immediately". In a meeting with HHS personnel several years ago the "immediate completion" of clinical services notes was interpreted as completed and signed "the day of the</p>	Danielle R. Varnedoe, M.A., CCC-SLP SCSHA Vice President of Clinical and Professional Affairs Board Members, South	email

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	<p>service”. Requests to change the timeline were not approved by HHS personnel.</p> <p>The “day of” completion and signing of clinical service notes for private providers practicing speech-language pathology is more strict and restrictive than for most other providers billing Medicaid under Private Rehabilitative Therapy services. A review of available provider manuals reveals variation in the requirements regarding clinical service notes across providers. Licensed Independent Practitioners Rehabilitative Service Providers, FQHC Behavioral Health Services Providers, and RHC Behavioral Health Services Providers are allowed up to 10 days to complete and file clinical service notes. Other provider manuals specify a caveat which states that “providers are to document immediately after the service but, if this is not possible due to the nature of the service ... have up to 10 days from the date of service”. This caveat applies to Community Mental Health Providers, Local Education Department Providers and Rehabilitative Behavioral Health Services Providers (the latter are encouraged to complete clinical service notes immediately but are allowed up to 10 days). Lastly, Early Intervention Service Providers have a time period of “within 7 calendar days from the date the service is rendered” to complete clinical service notes.</p> <p>Recommendation: The South Carolina Speech, Language and Hearing Association respectfully requests that HHS review and consider a revision to the “immediate” and “day of” requirement for speech-language pathologists who are private therapy rehabilitative providers. The “immediate” and “day of” requirement currently places a tremendous burden on these providers. A degree of flexibility in the timeframe, as allowed for other providers, would greatly alleviate this burden. The board is open to meeting once again with HHS personnel to discuss options to this timeline.</p>	<p>Carolina Speech, Language, Hearing Association South Carolina Speech-Language-Hearing Association</p>	
Provider Service Center			
	<p>Provider service center doesn't provide best direction to correct claims. Expertise is lacking.</p> <p>Recommendation: Would like a single contact to escalate to and receive good information</p>	<p>Susan Mills/Spartanburg Regional</p>	<p>Spartanburg Forum</p>
	<p>Provider service center can only handle three issues at a time.</p> <p>Recommendation: Allow for more issues if they are similar</p>	<p>Brice Elvington</p>	<p>Florence Forum</p>
Reimbursement			
	<p>Receive reimbursement at 65% of OB rate. Have about 5 codes (59409, s8415, 99354, 99215, 99402).</p> <p>Recommendation: Would like reimbursement at 85% of reimbursement rate.</p>	<p>Brandy Brandfass/ Licensed midwife Charleston Midwife/ President of Midwife Association</p>	<p>Charleston forum</p>

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61 104 DHEC birth center regulations	<p>Birth Center owners are statutorily required (61 104 DHEC birth center regulations) to have second licensed provider in house during delivery, but Medicaid does not reimburse for second provider.</p> <p>Recommendation: Look at reimbursement for second licensed provider.</p>	Brandy Brandfass/ Licensed midwife Charleston Midwife/ President of Midwife Association	Charleston forum
	<p>Birth centers are being paid on facility fee rather than facility service fee. Service fee includes second person, registered nurse, supplies, etc.</p> <p>Recommendation: Need a language change to facility service fee. Bill in ACA mandates that Medicaid covers facility service fee.</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers	Charleston forum
	<p>Physicians can come in and bill for delivery when a mother is brought in with certified nurse midwife.</p> <p>Recommendation: Need to pay nurse midwife for time spent. Physician should only be reimbursed for delivery.</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers/	Charleston forum
	<p>Do not break even with Medicaid mothers. Only accepting 5 Medicaid recipients per month.</p> <p>Recommendation: Would like to take more Medicaid mothers. Get paid for home visits for FFS Medicaid, but MCOs do not pay for this.</p>	Lesley Rathbun/ Certified Nurse Midwife/ Owner, Charleston Birthplace/ President of American Association of Birth Centers	Charleston forum
	<p>2 80% of revenue is from Medicaid. Must go through DDSN and cannot bill directly. Operating on rates that were established in 2008.</p> <p>Recommendation: Direct bill would allow for higher rate.</p>	Rick Magner/ Disability Board of Charleston	Charleston forum
	<p>I have a small private practice as a counselor and geriatric care manager. This is a part time job (I also work part time at Oconee Medical Center). Last year I only made about \$7000 on the private practice business. I am a Medicare and Medicaid provider for mental health services.</p> <p>This month Medicare (through SCDHHS) charged my small business \$532 to re-validate my enrollment in Medicare and Medicaid. The represents about 7% of my profit in 2013. I have heard</p>	<p><i>Note: This was passed along to SCDHHS by the SC Department of Revenue</i></p> <p>Eunice Lehmacher,</p>	email

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	<p>several of my colleagues say that they were considering no longer accepting Medicare or Medicaid because of this new re-validation fee. Although none of them was considering closing their business, it does limit the care for the poor and the elderly if fewer counselors take Medicare and Medicaid. I think the US or SC government should bear the costs of validating providers (as they always have before). We need to do all we can to allow more counselors to take Medicare and Medicaid, not put hindrances in their way.</p> <p>Also, it hurts my business that Governor Halley declined the funds for Medicaid available from the Affordable Health Care act. Counselors such as me are often asked to help the poor with mental health services pro bono and we do this. But there is a limit to how many we can see, and each pro bono client I see means I have less time for a paying client. Many of the poor are suffering from mental health problems (depression because they couldn't find work; PTSD because of childhood abuse or military services; anxiety and panic disorders because of trauma in childhood and in poorly run schools and day care).</p> <p>Recommendation: I suggest SC take the federal funds from Obama care which would provide additional health coverage for the poor. Money spent giving them additional health care would not only help me and my colleagues, but also help the poor to get better, get jobs, stay out of jail, and be better models for their children. Please reconsider the refusal that is hurting out state (and our small business providers). Taking the federal funds would also help the hospital where I work be more solvent since more people would have insurance. I am so pleased to hear about the states that are starting their own health insurance exchanges as a result of the new Affordable Care act. SC's decision to not take the federal funds makes me want to move to a state that has more concern for its poor and the sick and takes help to provide services for them. I find the Governor's argument about not taking the funds (SC would later have to pay for the increase) weak. It seems like she is unaware of the needs of the poor and sick when I hear her talk about taxes and federal programs.</p>	LISW-CP Lic. Independent Social Worker-Clinical Practice	
Disproportionate Share in Proviso 33.34	Addition to the current regulatory burdens addressed we would also like to comment on the proposed requirement concerning Disproportionate Share in Proviso 33.34. The Proviso would require hospitals to “obtain a patient attestation to determine whether or not the individual receiving uncompensated care has access to affordable health insurance or does not have other means to pay for services”. This will be an additional form to be signed by the patient increasing the administrative paper work burden for hospitals. Often determination of charity status or access to third party coverage occurs after the patient has been treated. We would also suggest that if this attestation is determined to be necessary, it be delayed until there is a better understanding of how the health insurance exchanges will work and no earlier than State Fiscal Year 2015.	James R. Walker, Jr. Senior Vice President, Regulatory and Workforce South Carolina Hospital Association	email; hand-delivered

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	<p>Many of our patients are under the impression that we get paid our full fees by Medicaid and that we are getting rich by providing healthcare services to Medicaid patients. We actually lose money every time we see a patient with Medicaid, as our office is not set up to profit from Medicaid. We don't double book appointments and the dentist allows parents back with their children and spends time talking to each patient AND parent. For this reason, we are limited to how many Medicaid patients we can see and have strict rules about no-shows and/or not following through with recommended treatment. Every time there is a rate reduction in the fee schedule, we accommodate this by decreasing the number of Medicaid patients we can see. Every time the amount of paperwork for appeals and authorizations goes up, we decrease the number of patients we can see. As other costs go up, that also affects how much Medicaid we can see as our way of "giving back to the community" or "charity work".</p>	<p>Brice Elvington Florence Pediatric Dentistry</p>	<p>email</p>
	<p>We are at full capacity with our schedule, so we have blocked off certain days and times to see Medicaid. The main reason we do this is because Medicaid insurance is different than all the others in that everything falls on us to be sure their insurance is active, that they haven't been to another office since their last visit, and that certain codes are only billed at certain ages. If anything gets denied because of these things, we take the loss (versus non-Medicaid where the parent is responsible and it's between them and their insurance to fight about). Patients get mad at us for only scheduling on Thursday mornings and get more upset when we don't reschedule their broken appointments. Our analogy is when Chick-Fil-A has "free chicken sandwich day", they have the supplies and resources to give out free chicken sandwiches set aside for that particular day. If you don't show up, you can't go back a week later and demand your free chicken sandwich because you failed to show up on the correct day.</p>	<p>Brice Elvington Florence Pediatric Dentistry</p>	<p>email</p>
<p>Affordable Care Act, Part II, Employer Responsibilities, Sections 1511 – 1513</p>	<p>While I understand that this review is not considering regulations established to meet federal requirements, my comments address South Carolina's ability to provide personal care services once the insurance requirements of the Affordable Care Act take effect, specifically those found in Part II, Employer Responsibilities, Sections 1511 – 1513. My comments pertain to policy and procedural issues that affect an employer's ability to successfully conduct business 2014 and thereafter. As you know, beginning in January 2014, employers that are deemed large employers under the Affordable Care Act will be required to provide affordable health insurance or pay a \$2,000 per employee penalty, with no penalty for the first 30 full-time employees.</p> <p>As a business owner with over 700 employees that provides services in 27 counties in our state, I am aware first hand of the challenges we face in providing great service to our clients. Among the array of services Nightingales Nursing & Attendants provides is skilled nursing care, respite care and in-home companionship. We are one of the largest providers in this market in South Carolina.</p> <p>Much of the work we do is with your Department. The hourly payment rates for home health care and other personal care categories currently do not include the cost for health insurance. Generally this has been an industry that does not provide health insurance as part of its compensation package. In fact,</p>	<p>Gloria Kasler, RN, Administrator Nightingale's Nursing & Attendants</p>	<p>email</p>

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	<p>payment rates for the categories of care Nightingales provides is very close to the hourly rates we pay our employees. There is little margin, and in some cases no margin, for profit. For example, companion care is reimbursed below actual costs. However, we provide companion care and both levels of personal care because it is a service our clients need and as well as to provide a full complement of services to our community. We now are seeing RNs and LPNs being hired at rates that are dangerously close to our reimbursement, which when taken with the insurance costs, the risk involved and overhead, seriously affect the program's integrity. Trying to recruit and retain good nurses is difficult given that we compete with hospitals and nursing homes – both of which have better benefit packages. The constraint reimbursement rates currently place on compensation almost makes it impossible.</p> <p>Recommendation: wanted to take this opportunity to urge DHHS to move forward with consideration to adjust payments made under these contracts to include the costs we will see this coming January. Costs for providing insurance will exceed \$6,000 per employee, plus any increases that will be seen in the large group market as a result of changes required by the ACA. Even with an employer paying 70 to 75% of the cost of insurance, the total cost of providing insurance will be between two and three dollars per work hour. Another option would be to not provide insurance and face the \$2,000 penalty. For Nightingale's, the penalty would be over \$400,000 each and every year. Without adjustment in the payment rate, an employer's only other option would be to reduce the number of full time employees. The insurance market is in a state not seen before with tremendous uncertainty in the marketplace. I have contacted two large insurance carriers, the largest in the state and one of the largest nationwide, Blue Cross Blue Shield of South Carolina and United Healthcare, neither would offer a quote. My understanding is that there is no requirement for any insurance company to write a policy in this market. And while South Carolina's insurance exchange will become operational this fall, it will not be able to consider writing policies for large employers, those with more than 50 employees, until 2017.</p> <p>I appreciate your consideration of these issues. They do impact both the cost and quality of care in a market that is already a very challenging one in which to operate. I will be very happy to provide any additional information you or your staff may need.</p>		
DHHS 149 Form, DHHS 151 form	<p>Ø Another issue is the entire process of the nursing home room & board billing for nursing home/hospice-mutual patients. This NH billing is currently done by the hospice Department, on behalf of the nursing home (and in my humble opinion, there is no logical reason for this). The billings always run, at a minimum, a month behind. The nursing home is required to submit a TAD to Medicaid. The nursing home then, in turn, receives an ECF with a claim edit of 976 from Medicaid. This then prompts the NH to bill the hospice Department via a manual invoice. We then have to manually calculate the patient's daily NH rate, at a reduced 5% rate from what is shown on the ECF/invoice. Then, once again, a hardcopy claim is submitted to Medicaid. Upon receipt of these</p>	Jan Burton Reimbursement Coordinator HospiceCare of the Piedmont, Inc.	email

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	<p>claims at Medicaid, they are then again manually entered at Medicaid – causing much room for error. Our NH room & board claims have denied numerous times due to keying errors on Medicaid’s end; it is quite a burdensome process to get this straightened out. And to top it all off, the hospice must pay the NH at 100% of their invoice charges although Medicaid only pays 95% of those charges. This means we, the hospice Department, are paying 5% more to the NHs – again, extremely time-consuming as we are doing all the work, manual computations, and manual hardcopy submissions.</p> <p>Recommendation: Ironically, several years ago, we were allowed to submit these NH room & board claims electronically, via Web Tool. In today’s medical-electronic world, manual calculations and hardcopy submissions should be a thing of the past! Better yet, regarding this nursing home room & board billing, the hospice should be taken out of the picture completely.</p>		
<p>procedure code J1055 was deleted/replaced with J1050</p>	<p>On another topic where SC Medicaid is impacting our practice negatively: three and half months after the Depo-Provera procedure code J1055 was deleted/replaced with J1050, there is still not a way to report this to Medicaid. There is no procedure in place to do so. A patient receives 150mg for contraceptive purposes. The new/replaced code only reports 1 mg.</p> <p>I went to Medicaid last week to meet with the appropriate person regarding these issues. Again; to date, these issues are still not resolved. It is very concerning that it is three and a half months after both of these new policies were enforced, and there is still no procedure in place to correct the problem.</p>	<p>Paula B. Hinton Office Manager Greenwood Center of Gynecology, LLC.</p> <p>Provider: J. Randall Erickson, M.D Practice Name: Greenwood Center of Gynecology, LLC.</p>	<p>email</p>
	<p>Problem: The Licensed Midwives (LMs) are reimbursed at 65% of the physician rate.</p> <ul style="list-style-type: none"> • This creates a very LOW fee collected by providers for full-service prenatal, labor, birth, postpartum, and newborn care. The average fee for a normal, healthy woman and newborn, for ALL care provided, ranges from \$1100 to \$1800, depending on when she enters into care with the LM. The average self-pay fees for LMs range from \$2400-\$4000 for home birth. • The average prenatal visit with an obstetrician is 5-8 minutes long. Depending on the weeks’ gestation, and the topics at hand to discuss, the LM spends an average of 45-90 minutes with each client, at each appointment. • The average face-to-face time spent delivering labor, birth, and postpartum care to a first-time mother, who is a Medicaid recipient, in my practice, has been 12 hours, since my business opened in 2007. This is in home, one-on-one care, not being provided by nurses, assistants, etc. • The cost savings by increasing reimbursements to LMs, and encouraging more midwives to accept Medicaid, will be multi-factorial. Data specific to LM care is difficult to obtain, but the January 2013 study “Outcomes of Care in Birth Centers: Demonstration of a Durable Model” provides current, applicable, significant, and fiscally-impressive data, as five of the six licensed birth centers in SC are 	<p>Brandy Brandfass, RN, LM, CPM President, South Carolina Licensed Midwives Association</p>	<p>email</p>

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	<p>owned and operated by LMs.</p> <ul style="list-style-type: none"> o Medicaid facility reimbursement for birth centers varies widely across states in which birth centers are reimbursed; however, in 2011, the average Medicaid reimbursements in general were similar to national Medicare reimbursement rates. The Medicare facility reimbursement for care of mother and newborn for an uncomplicated vaginal birth in a hospital in 2011 was \$3998, compared with \$1907 in a birth center. Thus, the 13,030 birth center births in this cohort saved an estimated \$27,245,469 in payments for facility services compared with hospital vaginal births at current Medicare rates. Even with birth center facility reimbursement rates increased to more equitable levels, cost savings would remain significant. • The cesarean birth rate in this cohort was 6% versus the estimated rate of 25% for similarly low-risk women in a hospital setting. Had this same group of 15,574 low-risk women been cared for in a hospital, an additional 2934 cesarean births could be expected. The Medicare facility reimbursement for an uncomplicated cesarean birth in a hospital in 2011 was \$4465. Given the increased payments for facility services for cesarean birth compared with vaginal birth in the hospital, the lower cesarean birth rate potentially saved an additional \$4,487,524. In total, one could expect a potential savings in costs for facility services of more than \$30 million for these 15,574 births. <p>Recommendation: Increase the Licensed Midwives reimbursement rate to 85% of the physician rate.</p>		
	<p>Problem: Licensed Midwives are authorized to bill for exceedingly limited ICD-9 and CPT codes that do not adequately reflect the services provided.</p> <ul style="list-style-type: none"> • LMs are required to bill under a specific modifier, and there are approximately 25 Evaluation/Management codes for which we are able to receive reimbursement. There are 4 diagnostic codes that we are permitted to use. These extreme limits, in no way, reflect the full scope of services we provide to mothers and babies. • One example: when a woman has a need to transfer care to a hospital for a prolonged labor, the LM may only bill for services that result in reimbursement of \$163.23. This typically happens after many, many hours of one-on-one, direct care. Private insurance carriers will permit providers to bill 99355, which is defined as Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes (List separately in addition to code for prolonged physician service). It IS a code that is reimbursable by Medicare; see Attachment 1. • Expanding the billable codes to the full repertoire will permit more accurate coding, which aligns with the National Correct Coding Initiative begun in August, 2011. <p>Recommendation: Eliminate the burdensome limitations on the allowable coding for LMs during the</p>	<p>Brandy Brandfass, RN, LM, CPM President, South Carolina Licensed Midwives Association</p>	<p>email</p>

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	transition to ICD-10, permitting us to more accurately bill for the services provided.		
	<p>Licensed Birth Centers in the state of South Carolina are required by regulation to have a second care provider (LM, CNM, RN, MD) present for each birth. However, Medicaid does not allow us to bill for that second care provider. This affects the primary midwife who then must compensate the second required person thereby reducing her already low compensation.</p> <p>Recommendation: Allow for this second care provider to bill for themselves at a reasonable rate.</p> <p>Dr. David Anderson, Professor of Economics and Specialist in Out-of-Hospital Birth Economics, at Centre College in Kentucky, has studied the cost-effectiveness of home birth for over a decade, and his “Notes on the Economics of Out-of-Hospital Maternity Care” [Attachment 2] includes the following:</p> <p>*If we increased the home birth rate to just 5%, we would realize a savings of \$1.3 billion annually.</p> <p>*If we increased the number of birth center deliveries by the same modest amount, we would add \$674 million in savings. Factoring in the reduced cesarean section rate that accompanies out-of-hospital delivery under the care of Certified Professional Midwives, we would see an additional savings of \$341 million annually.</p> <p>*Factoring in the reduced costs that would result from the reduction in preterm and low-birth weight deliveries would add another \$84 million in savings each year.</p> <p>*If the cost of routine hospital deliveries and the inflated cesarean section rate was reduced by as little as 15% due to increased competition in the maternity care market, we would realize an additional \$3.5 billion in annual savings.</p> <p>Total annual savings realized by expanding access to Certified Professional Midwives and Out-of-Hospital Maternity Care: \$9.1 billion</p>	Brandy Brandfass, RN, LM, CPM President, South Carolina Licensed Midwives Association	email
	<p>Regulations require 2 midwives on staff, but not paid for second.</p> <p>Recommendation: Would like reimbursement of second midwife.</p>	Linda Weomer/ Labors of Love Birth Center	Spartanburg Forum
	<p>No codes for breastfeeding.</p> <p>Recommendation: Align payment with nurses who are reimbursed for breastfeeding appointments.</p>	Linda Weomer/ Labors of Love Birth Center	Spartanburg Forum

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	<p>Not allowed to use code to bill for transfer.</p> <p>Recommendation: Allow use of code.</p>	Linda Weomer/ Labors of Love Birth Center	Spartanburg Forum
Third Party Liability			
OBGYN billing, insurance, collections, etc.	Why is it when a pregnant patient has a Commercial Insurance, i.e. Aetna, BCBS, etc. and Medicaid secondary that the Medicaid doesn't pay like a secondary if it was a Commercial Insurance? It should be treated the same as if someone had BCBS primary and say Aetna secondary. If BCBS pays more than the secondary allows, no money is due the provider.	Dena Taylor AR Specialist Resource One	email
	<p>Other Health Insurance updates are not timely.</p> <p>Recommendation: Need timely updates, including update to MCO</p>	Denise Downey/SRMC/	Spartanburg Forum
Training			
	<p>Organization must be a current Medicaid provider before attending "Live Provider Workshops". The website lists Medicaid Basics Training workshops as offered once a month.</p> <p>Knowledge about this requirement was obtained when attempting to enroll in a training course online and by the phone. Online there was a required box for provider number. The SCDHHS staff on the phone did not know where to find this requirement in writing. But stated "unfortunately you must be a provider to register." We are currently working to meet the SCDHHS requirements of becoming accredited in an effort to enroll as a Medicaid Provider. We anticipate obtaining national accreditation through Council of Accreditation ("COA") by June 30, 2013. As we strive to meet requirements for COA and Medicaid Provider enrollment, we believe it beneficial to receive Medicaid Basics training prior to our acceptance as a Medicaid provider to ensure our programs have the required appropriate staff and policies in place. Pendleton Place for Children and Families is seeking ways to improve quality and efficiency throughout each of our programs and Department as a whole. Therefore, receiving Medicaid Basics Training would be beneficial for all parties involved as it permits:</p> <ul style="list-style-type: none"> • State agencies and affiliate programs time to properly plan for staffing needs (i.e., training) and hiring of appropriately credentialed staff • Agencies additional time to make necessary changes in policy, procedures and daily operations to meet Medicaid requirements • Agencies and programs to minimize the number of errors submitted for Medicaid claims submissions • Agencies and programs with the means to serve the community based on early receipt of information and knowledge regarding Medicaid Standards and Policies. <p>Recommendation: receive Medicaid Basics training prior to our acceptance as a Medicaid provider</p>	Laurie Roven Executive Director Pendleton Place for Children and Families	email

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Transportation			
NEMT	<p>Non-emergent transport services need to be enhanced and education provided to the carrier(s). · Difficulty in arranging transport for patients with oxygen is frequently expressed by hospital discharge planners.</p> <ul style="list-style-type: none"> · Length of time waiting for the transport is an issue even though the 3 hour notice was honored. Delays cause a backup in the ED and inpatient areas when hospitals cannot discharge non-acute patients for the intake of new patients. · Appropriate method of transport is also a concern expressed with the overuse of ambulance services. · Getting authorization in a timely manner is an issue expressed by hospitals. · Carrier staff knowledge is frequently a stumbling block to an efficient process and written policies and procedures with required education is an effective way to make quick corrections. 	James R. Walker, Jr. Senior Vice President, Regulatory and Workforce South Carolina Hospital Association	email; hand- delivered

6.0 APPENDIX B: INTERNAL COMMENTS RECEIVED

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Appeals		
	<p>Since Keystone Peer Review Organization (KePRO) began issuing prior authorizations for certain provider services, the Division of Appeals and Hearings has had a 33% spike in provider appeals. The provider appeals revolve around the same issues in general: (1) KePRO refuses to even discuss the issue with the provider and instead directs the provider to file an appeal (which requires an evidentiary hearing in Columbia), or (2) the Medicaid recipient has received retroactive eligibility and the provider has requested prior authorization after receiving the notice of eligibility yet KePRO denies for timeliness. The Division of Appeals and Hearings has set up over twenty (20) of these appeals and none have gone to hearing because SCDHHS Medical Services has reversed KePRO's determination. This certainly leads one to think that KePRO has been directed to deny prior authorizations in this manner and to make the providers jump through so many hoops via the appeals' process that the providers will simply go away and SCDHHS will save that money. Since providers are now requesting hearings in much greater numbers, it is obvious that they have figured out that if they file an appeal, SCDHHS will reverse the decision and properly pay them.</p> <p>Recommendation: Train SCDHHS' agent, KePRO in such a way that they follow SCDHHS' policy when making prior authorization determinations. If that does not work, sanction KePRO when they do not follow SCDHHS' policy in the work that they perform for SCDHHS and for which they are receiving a large amount of money from SCDHHS.</p>	Robert French/ Appeals and TPL Services
	<p>We are receiving many provider appeals related to KePRO, DentaQuest & Med Solutions denials. Many of these could be related to the fact the providers are still becoming familiar with the PA process and have not followed procedures to obtain their PAs. I am not familiar with the process KePRO and other contractors use but it appears when they have denied a service, they instantly direct the provider to appeal to DHHS. Issues that they could resolve like letting the provider know that a doctor's statement of medical necessity was missing, end up in appeals instead of being resolved quickly by the contractor. Another issue is there appears to be a looping problem with policy related to obtaining certain DME equipment like specialized electric wheelchairs. This is a problem that involves state and federal policy, especially when a beneficiary also has private health insurance. One example was an appeal a HASCI Waiver participant filed needing a "standing wheelchair". He was qualified for a new chair because his current chair was 10 years old. He had BC/BS insurance, Medicare, Medicaid and Waiver coverage. BC/BS denied the chair as a non-covered item. Medicare will not give prior authorization and had downgraded coverage for Group 4 chairs to Group 3. The chair is very expensive so the provider does not want to order the chair without confirmation it will be paid for. Medicare & Medicaid policies prohibit paying for DME equipment until it has been delivered to the beneficiary. If a PA was issued, it does not guarantee payment. Medicaid does not want to cover the chair unless Medicare denies payment but the provider can't order it unless he knows it will be paid for. Also Medicaid's policy often follows Medicare's about what is covered so if it is not covered by Medicare, it may not be covered by State Plan Medicaid. The HASCI waiver should cover items not covered by State Plan Medicaid but they denied coverage and their policy</p>	Betsy Schindler/ Appeals and TPL Services

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	<p>states the waiver cannot pay for equipment the beneficiary already has. This means if the provider orders the chair, delivers it and then Medicare & Medicaid deny payment, DDSN will deny because he already has the chair in his home since it can take months to work through the denials from BC/BS, Medicare & Medicaid. This leaves the DME provider and beneficiaries in an impossible situation. Medicaid Policy: DME Manual pages 2-41 to 2-60 Wheelchairs, DDSN HASCI Wavier Manual, Medical Supplies, Equipment, and Assistive Technology pages 1 to 8, Medicare, Article 2/1/12 Non Medically Necessary Coverage and Payment Rules/Power Seating Systems and February 2004 CMS Article, Power Wheelchair Coverage Overview.</p> <p>Recommendation: It appears KePRO, DentaQuest, etc. need to work directly with providers to resolve PA denials so if a PA is denied there is a legitimate reason and not a technical issue that could easily be resolved. For example, denial should be for things like - an MRI is not medically necessary for someone with a sinus infection instead of the provider failed to send the proof of medical necessity within 3 business days. For the wheelchair issue DHHS & DDSN staff could create flow charts of the process required to authorize payment for equipment and see where there are continuous loops and dead ends for the providers. A review of authorization & payment policy for Medicare, Medicaid & DDSN could help identify areas that need revision or clarification.</p>	
Claims Processing		
	<p>Non-Claim Related Payments - We also receive calls regarding payments that the provider has not received any correspondence to explain what it is for.</p> <p>Recommendation: Make sure your contact list is up to date for providers and send a letter or e-mail explaining the payment.</p>	Karen Maine/ Ancillary Reimbursement
	<p>Prior authorization process for Providers.</p> <p>Recommendation: Invest in more resources to perform post reviews and provide training/progressive reviews with those problem providers, instead of making all providers jump thru the hoops. Seems some providers have to be performing the appropriate procedures, so it seems wasteful to have all doing this.</p>	Michael Jones/ Eligibility, Enrollment and Member Services
	<p>Doctor offices call to complain about the turnaround time of payments.</p>	Coriless McFadden//York Eligibility, Enrollment and Member Services
Community Long Term Care		
	<p>I am not sure if this is the type suggestions you are looking for! 1. Participants that want to apply for Medicaid and access a CLTC frequently apply and re-apply for Medicaid and CLTC only to have the application closed over and over because the applicant never completes the financial application. Most people do not complete the application because they do not read, do not have anyone to assist them and don't understand the application. If there was somehow that someone from the Medicaid Eligibility office could be available to make home visits to assist the applicant and</p>	Vanessa Shalosky/Horry County Community Long Term Care

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	<p>assist with the application completion, we would not spend so much employee manpower opening and closing the same cases over and over again- and the applicant would get the much needed service!</p> <p>Recommendation: Medicaid Eligibility would have case workers trained to visit applicants who need assistance in completing required applications.</p>	
	<p>CLTC Providers - Contractually, these providers are bound to file annual cost reports for their ADHC (Adult Day Care), PC I and II (Personal Care Aide) and Medicaid Nursing services. Many times we hear quite a bit of grumbling about the preparation of these reports. These are small "mom and pop" enterprises many times, and they state that the Medicaid program does not offer payments great enough to afford an accountant to prepare these reports. Thus they complete the reports themselves, struggling to understand our financial format as these folks are generally clinical in background. To compound their frustrations these are used only for rate setting purposes and not cost settlement, thus they do not see an immediate or financial gain for their efforts.</p> <p>Recommendation: We are currently evaluating the necessity and practicality of these reports given alternative means of justifying the CLTC rate structure.</p>	Debbie Strait/ Controller
	<p>With CPCA cases the mothers desire more flexibility for use of hours.</p> <p>Recommendation: If hours could be authorized for the week instead of day by day the families would have more flexibility.</p>	Sylvia Jordan/Greenville Community Long Term Care
	<p>CLTC is to start to evaluate CPCA cases yearly. Many times with the CPCA cases, DDSN or DSS has the CPCA client on their case load, and they also do evaluations on these clients.</p> <p>Recommendation: Could the yearly evaluations that DDSN or DSS be used or better yet, the CPCA cases be moved to those case managers at those agencies, so that the nurse is not case managing those cases? It would seem that this would save the state money by having one Department managing a case. The nurses are overburdened with CPCA cases and there is no limit as to how many cases we are assigned. The number has more than doubled, almost tripled in the time that I have been employed with the state.</p>	Sylvia Jordan/Greenville Community Long Term Care
	<p>As soon as a case shows up on the dashboard of the support person, that support person is instructed to immediately assign the case to the nurses. Cases are assigned daily. There is no regulation of amount of cases assigned, but the policy stands as to timeliness standards. We are unable to keep up with the flow of case assignments. In addition we are supposed to be working in CPCA evaluations as well now.</p> <p>Recommendation: Could we have a state wide policy so that all area offices are in one accord as to the number of cases assigned to nurses?</p>	Sylvia Jordan/Greenville Community Long Term Care
	<p>So many new policies that require more work on our nurses and social workers has been quite a burden. Our policy writers need to consider this. Home visit assessments have increased by one hour to equal at least a two hour visit for our nurses.</p>	Rosalynn Radloff/Greenville Community

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		Long Term Care
Dental		
	<p>I do not know if this is a statute but in considering the Medicaid budget a real need is for vision and teeth. Home delivered meals are provided but people have no teeth. Poorly chewed food impacts health as good health starts with the stomach and nutrients are retained in the small and large intestines. At the very least it is a matter of self-esteem. Poverty does not mean you do not care how you look.</p> <p>Recommendation: Make it feasible for dental groups to benefit from the Medicaid population. Provide some incentive and also transportation. Have a yearly dinner of thanks for the dentists a recognition by the Governor.</p>	<p>Laura Vallone/Horry Long Term Care and Behavioral Health Services</p>
	<p>Adult customers very upset concerning dental coverage for adults.</p> <p>Recommendation: Offer more dental benefits to adults.</p>	<p>Chelsie Thompson/Williamsburg Eligibility, Enrollment and Member Services</p>
	<p>No dental, vision care.</p>	<p>Faye Usry/Edgefield Eligibility, Enrollment and Member Services</p>
Eligibility		
	<p>It is not always true that the county resident will apply for nursing home Medicaid or community long term care Medicaid in the county in which they live. Example: Georgetown, Williamsburg and Marion Counties have to apply in Horry County. Clarendon County residents apply in Horry County.</p> <p>Recommendation: Each county resident should be able to make whatever application is needed in the county in which they live. It is most confusing trying to explain to someone that lives in one county that they have to apply in another county.</p>	<p>Vanessa Shalosky/Horry County Community Long Term Care</p>
	<p>Sending applicants to apply for unemployment benefits if they are clearly not eligible. IE: a stay at home mother who would pay more for daycare than she would make on her job. It is her decision to stay at home with the kids and to send her for unemployment is burdensome for applicant and caseworker. In order to be able to receive UCB, one must be actively seeking employment.</p> <p>Recommendation: Not send applicants who have a legitimate reason for not working.</p>	<p>Suzanne Knight/Pickens County Eligibility, Enrollment and Member Services</p>
	<p>Sending parents with an open PHC case to apply for UCB at review. Even if they were receiving benefits and exceeded the income limit, children are in a protected period and cannot be closed. Same situation with spouses of pregnant women.</p>	<p>Suzanne Knight/Pickens County</p>

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	Recommendation: Do not send them to apply for UCB	Eligibility, Enrollment and Member Services
	<p>Clients who are dual eligible or SLMB only are having a very difficult time with out of pocket expenses. Most dual eligible customers complain about how even though they have both Medicare and Medicaid they are still over burdened with out of pocket expenses.</p> <p>Recommendation: Have some type of assistance to help people with those out of pocket expenses.</p>	Nancy Bracey/Marlboro Eligibility, Enrollment and Member Services Dual eligibility (ABD/SLMB) and Institutional
Section 1877 of the SSA, 42 U.S.C. Section 1395	<p>Customers who were eligible under SSI and then get switched over to SSA disability and that check is just over the income limit for ABD and will have no type of health insurance for 2 (two) years until their Medicare becomes effective. Most comment saying that "what, they just expect me to die?" Of course I have no answer for them.</p> <p>Recommendation: Implement a spend-down program. Where deductions can be made for some household expenses such as rent, utilities, phone, and out of pocket medical expenses.</p>	Nancy Bracey/Marlboro Eligibility, Enrollment and Member Services Dual eligibility (ABD/SLMB) and Institutional
	<p>Income verification from Veterans Administration is a barrier or burden to timely processing of Medicaid applications. VA is difficult to work with. They don't easily communicate with Medicaid Caseworkers as another Department to Department.</p> <p>Recommendation: The best option to reduce this burden would be to have an interface between Medicaid Eligibility and Veterans Administration. This could be very similar to the Social Security interface. When we pend an application, it would automatically match up. This would help to expedite the application process.</p>	Lisa Adams/Darlington Eligibility, Enrollment and Member Services
	<p>Recently, the feds made it mandatory for persons who receive incontinent supplies to have a medical order from the doctor in the chart. I would say the majority of participant's in our program need incontinent supplies. These were sent out 3-15-13 to all doctors. I don't know that doctors will sign these as some may not even know, for sure, if their patient is incontinent. Also, I feel the doctors who are presently being bombarded with these forms are going to charge Medicaid with every form they are required to sign. And, this has to be repeated each year--365 days from now for each participant. This is a burden on us and is costing Medicaid a lot of money. My participants do not like to talk about their problems, but I can assure you the persons I deal with need the supplies.</p>	Joan Booth/Horry Community Long Term Care Case Manager
	<p>More and more children that only need speech therapy are falling between the cracks. These children do not have any functional deficits, but need speech therapy which could change the quality of their life.</p>	Sylvia Jordan/Greenville Community Long Term Care

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	<p>Form 3313 - adds additional time to the completion of a case and it does not help. Computers that require trouble shooting too frequently. Applications that do not address the actual response needed. The information that is required causing client to make mistakes when answering the questions. Having caseworker to follow-up work to obtain information that could have been on the application if the questions were worded properly. I think the problem is those people creating the applications do not deal with the clients and the eligibility process directly. Un-realistic time frame to complete a cases; a case that has all required documentation and on a day that there are no calls to be answered, files to locate, problems and computer glitches to deal with could be completed on the time frame allowed to complete. With the eligibility process being automated it now takes a great deal of time to review an application, check the necessary sites, check the hard copy file and proceed as information at hand dictates.</p> <p>Recommendation: Get rid of form 3313. Consult caseworkers what is the actual information that is needed on the application and how it would help to word the question. Research the actual eligibility process as it is experienced by the caseworkers so that a true picture can be obtained of the process as it is now, not as it was before. The glitches in the computer I do not know if there is an answer to that; however the fact that they break down should be taken into consideration.</p>	<p>Carmen Roa/Aiken Eligibility, Enrollment and Member Services</p>
	<p>Per feedback from recipients looking to obtain medical health insurance from the state, they see as a burden the fact that the income limits are different for different categories. The elderly feel that their fixed income should not be a hindrance in obtaining Medicaid because their resources are so low.</p> <p>Recommendation: I believe for the programs that are offered to those who are on fixed income, more specifically on ABD and SLMB the income limit should be the same. It this I believe the program would be more affordable to them and it would lend itself to have more qualifying individuals and/or couples that are elderly and in real need of medical services.</p>	<p>Luz Gonzalez/Laurens Eligibility, Enrollment, and Member Services</p>
	<p>SC requires that applicants/beneficiaries apply for unemployment benefits when they've paid in enough to the ESC system prior to approval of Medicaid benefits. ESC requires that their applicants complete interviews and other things before they will give a printout showing the applicants potential benefits. This delays approval of Medicaid. Also, applicants/beneficiaries are required to apply for unemployment benefits if the 3301 form we use to determine who is required to apply says they must--even when they've already been receiving benefits and may have exhausted their total benefit amount. We need a way to communicate with ESC to see if the benefits have already been exhausted.</p> <p>Recommendation: If we had a way to communicate with ESC where we could be told someone has applied for unemployment, that's all that would be required for the initial approval. We'd still have to monitor the case for a few weeks after to see if benefits started or not, the initial approval would not be as delayed. We need a way to communicate with ESC to see if the benefits have already been exhausted.</p>	<p>Elizabeth Miller/Barnwell Eligibility, Enrollment and Member Services</p>

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	<p>Clients complain about having to mail in applications and don't understand why they can't do everything on the internet. They complain about mail getting lost or the workers not putting applications or information in the system even when they drop off their information at the office.</p> <p>Recommendation: Do more applications online</p>	<p>Mary Thigpen/Columbia Eligibility, Enrollment and Member Services</p>
	<p>Most SCDHHS "Notices of Adverse Action" do not comply with 42 CFR § 431.210. Eligibility "Notices of Adverse Action" will typically list the specific regulations that support the action as, "102.06.01". While the eligibility staff may know that this refers to a section of the SCDHHS Medicaid Policy and Procedures Manual, I find it hard to believe that anyone not associated with Medicaid Eligibility would know to what these 7 numbers refer. The typical SCDHHS Community Long Term Care Notification Form lists no specific regulation that supports the negative action. 42 CFR § 431.210 is written to ensure that a Medicaid applicant or recipient can readily determine the policy that directs the negative Medicaid action and in that way, can be prepared to appeal that determination or accept that determination. By not following federally mandated regulations, SCDHHS is causing more work for its staff and on its face, intentionally preventing Medicaid applicants and recipients from understanding how Medicaid works.</p> <p>Recommendation: Change SCDHHS' notices to comply with federal Medicaid policy.</p>	<p>Robert French/ Appeals and TPL Services</p>
	<p>Exception: The Transitional Medicaid Quarterly Report cannot be treated as a "Review" if they are not returned by the 21st day of the month following the month in which the quarterly report was received. The beneficiary must re-apply for Medicaid: There are too many non-fault variables that could create ineligibility due to review not returned by 21st day. The DHHS Form 3313, Medicaid Eligibility Worker Checklist, must be completed for every Medicaid eligibility determination except for deeming infants: Creates redundancy-extends processing times-choices are not exactly accurate Review Cat. 10 MAO – Nursing Home Annually :Usually, these cases nothing changes except for COLA which is already done usually, every year-redundancy Review Cat MAO - General Hospital Annually An alert will be generated quarterly to verify continued hospitalization: Since policy already states we are to set up a separate file and check on status of GH ever few months, an annual review hardly seems necessary, AND most individuals that are in GH cat, transfer either home or exparte to NH</p> <p>Recommendation: Allow TMA to reopen within 30 days of closure and resume normal review schedule. Allow EW to stop utilizing the 3313 as a "catch-all" mandatory tool. Let NH reviews stand as completed for single - SSA only income at COLA each year. It is very doubtful that a NH resident will strike it rich while receiving Medicaid NH assistance. Allow Applicants to apply and submit their applications online from the scdhhs.gov website. Allow applicants to access their own eligibility so EW's do not have to produce Approval/Denial Letters. Allow applicants to reorder their lost/stolen/not received Medicaid cards in the same way a person can order their Medicare cards online. Place scanning stations and application kiosks in lobbies of LEP sites. Making the applicants independent as possible creates less burden on all staff, admin and EW.</p>	<p>Jennifer Lane/Darlington Eligibility, Enrollment and Member Services</p>

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	Customers complain about the policy all the time	Anita Shaw/Charleston Eligibility, Enrollment and Member Services
	Requirement to apply for Unemployment benefits (MPPM 102.08.01) - as many local UCB offices have now closed, requiring beneficiaries to apply for UCB in order to receive Medicaid now places a burden on applicants. This is a particular problem for those who do not have reliable transportation, or computers with which to apply.	Rhonda Johnson/Allendale Eligibility, Enrollment and Member Services
	Customers are unable to get prescriptions on the same day that their eligibility is approved by the worker. Recommendation: Take an id and let the customer sign for the prescription.	Cheryl Brown/Georgetown Eligibility, Enrollment and Member Services
	FI-PHC review forms Recommendation: Express Lane eligibility should be used for all children under the PHC program. Annual review forms should be exparted if the child is a consistent participant of the food stamp program.	Cheryl Brown/Georgetown Eligibility, Enrollment and Member Services
	Why is there a separate sheet for the workbook and the checklist when processing a case? Recommendation: The workbook and the checklist should be combined. It takes a lot of time computing the information into these forms twice. I feel if you compute the information in the workbook, all of the information should be transferred to the checklist. For example, if I put the person's name, household, BG and income in the workbook, it should be transferred to the checklist checking off the information that was computed in the workbook.	Angela Chandler/Darlington Eligibility, Enrollment and Member Services
	Some clients are required for apply for unemployment benefits prior to eligibility determination. There is no interface connection with Employment Securities Commission to see if an application has been filed. This requirement is one of the most common hold-ups to decision-making and one of the most common errors seen by QC. Recommendation: Self-declaration or an interface with ESC showing application dates.	Elizabeth Miller/Barnwell Eligibility, Enrollment and Member Services
	This may not be a Regulatory burden, but the customers are stating that they have a hard time getting cash values of their Life Insurance Policies.	Marilyn Roberts/Lexington Eligibility, Enrollment and Member Services
	I have had several clients with varying types of cancer that have asked about cancer programs and why it is only	Amber

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	<p>available to women with breast of cervical cancer. "Politics" seem to play too much into certain clients getting attention. All anyone has to do is call the governor's office or the main office in Columbia and complain and their case goes to the top of the pile, even if the case is very new or the complaining individual has not been cooperating. I understand that the intention is to give people a more positive view of the Department, but it does more harm than good. For every one complaining, impatient client, we have many more that have done what they are supposed to and are waiting patiently yet get ignored because we have to jump the moment a client complains, whether or not it is legitimate. Appeals are also an area in which politics seem highly involved. If the appeal comes from a lawyer, Chamberlin Edmonds, or a hospital, it gets treated very differently than the average citizen appealing. Big money nursing home cases are often pushed through with undue hardships just because the family or nursing home makes a fuss – even when funds have clearly been transferred. It is very frustrating to us as workers because we do our job and follow policy, but then certain individuals are allowed to circumvent that policy. It feels like a waste of time when we know it will just get overturned by Columbia.</p>	Turner/Charleston Dual Eligibles
Policy 102.0801	<p>Completion of form 3301. Referring applicant to apply for UI benefits. Applicants consistently state that when they call or go in to apply - they are told that they are not eligible for Unemployment benefits or can't apply. They state that they are told that there is no need to apply as they will be denied. It appears to them that we are being difficult when they call and refer them to apply anyway. (Giving them "the run around")</p> <p>Recommendation: A written statement from the applicant that they have attempted to apply.</p>	Myra Drennan/Eligibility, Enrollment and Member Services
	30-day "wait" for CLTC services waiting list for CLTC services	Faye Usry/Edgefield Eligibility, Enrollment and Member Services
	<p>The current DHHS Form 181 process is an unnecessary burden for vendors and eligibility staff. Although the DHHS Form 181 was recently revised to be form fill able which improved processing somewhat, the entire process should be reviewed and simplified. Currently, the vendors email, fax or mail the forms to the local eligibility office. Then continually calls to check the status of those forms. The eligibility office reviews the form, and if needed authorizes, terminates, or make changes to the vendor payment and return the form to the vendors. Once received, the vendors submit the forms to third party billing to process the claims. That third party then has to decipher the information on the forms and submit for payment. This process just seems antiquated to me. Because we are currently in the process of revamping our antiquated MMIS mainframe and our Medicaid Eligibility Determination (but not really, because it's just a storehouse of data) System, I think now would be a good time to incorporate the vendor payment process into the system making it completely electronic. MPPM 304.23DHHS Form 181 (Notice of Admission, Authorization and Change of Status for Long-Term Care) (Eff. 01/01/10) The DHHS Form 181, Notice of Admission, Authorization, and Change of Status for Long-Term Care, is the form used by nursing facilities to bill Medicaid for a vendor payment. Eligibility workers and nursing facilities use it to communicate information about:</p> <ul style="list-style-type: none"> • Approvals • Changes such as: <ul style="list-style-type: none"> o Transfers to another facility o Admissions to or re-admissions from a hospital o Level of Care changes o Increases or 	Sherry Shuler/Florence Eligibility, Enrollment and Member Services

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	<p>decreases in recurring income • Terminations due to such things as: o Death of beneficiary o Expiration of bed hold • Medicare-sponsored admissions • Medicare terminations • Denials o If an applicant/beneficiary is denied for Medicaid or Vendor payment eligibility, one of the following reasons must be shown on the DHHS Form 181: § You failed to meet financial eligibility § You failed to meet non-financial eligibility § Vendor Payment denied, eligible for Medicaid card only</p> <p>Recommendation: I think now would be a good time to incorporate the vendor payment process into the MMIS and Eligibility determination systems making it completely electronic. The DHHS form 181 should only be used at initial determination for vendor payment. The names of all of the approved nursing home beneficiaries should be in an electronic system that the vendors, eligibility, and third party billing can access. The vendors should be able to update this system whenever there is a change in the beneficiary's status. Whenever there is a status change that requires eligibility to approve, the eligibility office/worker should receive an alert. The eligibility worker should be able to go to the system and enter a code for approval or make any necessary changes to recurring income. The vendor can then get an alert to review and submit to third party for payment.</p>	
	<p>5 year look back policy for Medicaid Eligibility for ABD/SSI related populations. This requires clients/authorized reps/third party assisters to have the client try to find 60 months of bank statements. This is a burden on many banks/clients as they do not have the history readily available.</p> <p>Recommendation: Allow a provision for what's readily available and an attestation on what is not readily available.</p>	Michael Jones/Eligibility, Enrollment and Member Services
Policy section 101.04.02	<p>The application must be added to the computer system in pending status within three (3) working days of its receipt. With the roll out of Onbase (our digital file system) our application processing time frame has went way outside the 3 day rule. I personally work the intake queue, where all applications are scanned once received. As of today (3/21/13) we are just now pending applications turned in and scanned on 2/22/13. Not only has the 3 day rule gone out the window, but we're looking at almost a month of waiting before the application is ever pended in MEDS or even looked at to determine if we have all needed info. This issue is compounded by the fact that workers are more worried about their numbers (as we were told there would be a "quota" put in place) so rather than taking time to really be sure we are requesting everything we need with the first contact, a lot of workers appear send checklists requesting the first thing they find missing. This results in multiple checklists being sent to clients over the course of the application process, often times each checklist asking for something different and sometimes unneeded.</p> <p>Recommendation: It is obvious that we 1) do not have enough workers in the regions. Even with the work load being spread out amongst the regions, too many workers are leaving and none are being replaced. It is hard to see the logic behind the concept of spreading the work around when all of the counties seem to be behind. In the end it is the clients and their children who are suffering.</p>	Jill Owens/Oconee Eligibility, Enrollment and Member Services

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	<p>Clients and their families have expressed concerns about their contact with the Medicaid Eligibility Office. These concerns include not receiving a response when messages were left and employee rudeness. Personally, as a registered nurse/nurse consultant, I have experienced this myself when trying to get a CSD (Client Status Document) back in a timely fashion.</p> <p>Recommendation: Perhaps Eligibility needs more workers and additional training.</p>	<p>Elizabeth Livingston/Richland Community Long Term Care</p>
	<p>Customers stating that the processing time for application is too long (45 or 90 depending on the type of application completed).</p> <p>Recommendation: With OnBase and the work distributed evenly, hopefully this will cut down on the application processing time.</p>	<p>Martha Chandler/Eligibility, Enrollment and Member Services</p>
	<p>Cannot get in touch with workers in the county to inquire about the status of the application submitted. They call the United Way Call Center to try to get assistance.</p> <p>Recommendation: Once the United Way Call Center is setup for OnBase, this will allow the worker to provide the necessary information to the customers regarding the status of their application and if additional information is needed the Call Center workers will be able to provide what is needed.</p>	<p>Martha Chandler/Eligibility, Enrollment and Member Services</p>
	<p>Customers between 19 - 64 years old not disabled, do not have minor children; therefore, do not fall within a category to qualify for Medicaid they call trying to get information on where or how they can get medical assistance.</p> <p>Recommendation: There needs to be some type of affordable insurance that this group can afford or a clinic where these individuals can get free medical and their prescriptions when needed.</p>	<p>Martha Chandler/Eligibility, Enrollment and Member Services</p>
	<p>Customers SSI end and they start to get SSA Disability and their income exceeds the income guideline to qualify for Medicaid they call wanting to know what they need to do.</p> <p>Recommendation: Same for this group, these are disabled individuals that cannot get Medicaid because they went from SSI to SSA disability and their income is too high. This group also, needs some form of affordable insurance, or free medical clinic and able to get their prescriptions.</p>	<p>Martha Chandler/Eligibility, Enrollment and Member Services</p>
	<p>Too many times a child is entered onto meds without checking to see if already in a bg, thus giving child two cases and two different rcp #'s. This takes long time to get done and to clear up the second case and get original rcp # reassigned</p>	<p>Carroll Little/Greenville Center for Pediatric Medicine</p>
	<p>Too many times a child is automatically given phc and not checked to see if there are other children in the family but they put child into its own budget group, even when application is for lif or phc and the other family members are listed and not checked to see if there is already an existing case already in existence for this child or all of the family. Thus giving the child two rcp numbers and we have to contact help desk several times a day to get this info cleared up, an</p>	<p>Carroll Little/Greenville Center for Pediatric</p>

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	extremely large group of wasted double time and effort to get child back into correct case group and assign its original rcp # to the child. thanks	Medicine
	Medical providers should have access to immediate eligibility.	Mary Bryson/York Eligibility, Enrollment and Member Services
	Clients are upset if their case is not process in a timely manner regardless if the county offices are short staff.	Harriette Priester-Smith/Aiken Eligibility, Enrollment and Member Services
	<p>We require our elderly clients to provide proof of any and all resources which at times is difficult for someone unable to drive or get out much, some do not keep every piece of paper that is required for proof of assets as required, it is stressful to them to get cemetery plot info, insurance policies, bank statements, vehicle info, info for their home, and the many other items we require. It seems a real injustice that we make our elderly clients jump through such hoops and the balance of our clients just answer yes or no to the asset question and are required to provide no proof of the statement. We really need to be for user friendly for our elderly/disabled clients.</p> <p>Recommendation: If we take the word of our clients for LIF,PHC,FP,PW and other FI categories when the amount of assets is \$30,000, why can we not take the word of the elderly/disabled when their asset limits are so much less.</p>	Sherry Anderson/Horry Eligibility, Enrollment and Member Services

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	<p>The beneficiaries have problems getting medical services because of managed care. A specific issue is with the OCWI program and dates of services. In some medical practices the patient cannot make the first appointment for services until their managed care is in place and they get their managed care card. Medicaid policy mandates that the OCWI (pregnant woman) has Medicaid coverage on the date that the Medicaid application is filed. They do not get into the managed care program until the following month, and if they are approved in the last half of the month they may not get into the plan until the second month following the Medicaid approval. The medical provider has the option to bill Medicaid in the interim period, but some medical offices will not bill more than one Department. So the pregnant applicant waits several months to see the doctor. In some cases the client is four or five months into their pregnancy before they are being seen by a doctor. The second issue that I am aware is the time lapse between the approval for Medicaid and the managed care enrollment packet that goes out to the client. The approval is valid in the Medicaid system, but the client does not show up in the managed care system. The client that is approved for Medicaid is not getting into a managed care plan for several weeks.</p> <p>Recommendation: The alternative approach for the OCWI would be for the managed care plan to pick up the case as soon as the client is Medicaid eligible without waiting until the normal enrollment. If the medical providers would bill Medicaid until the managed care starts for our beneficiaries that would prevent the gap as well. The second issue is a correlation between the Medicaid eligibility system and the managed care system. There are times when one does not deliver information to the other.</p>	Kit Frazer/Sumter Eligibility, Enrollment and Member Services
	<p>There are many Medicaid programs and each has rules and regulation specific to the program. This is a hardship on the applicant because they have to apply for and provide verification of different things at different times for members of the same family. The application process for the client is hard to understand. Policy is hard for the Medicaid eligibility worker to understand and the interpretation is different across the state.</p> <p>Recommendation: Medicaid policy needs to be streamlined. The application could be used as verification instead of requesting a second document to repeat the information provided on the application. Policy needs to be easy to understand and complete. There is a need for more computer matches like family court and probate so the eligibility worker could check child support and probation. The cases that require verification of resources should be worked by a group separate from the general Medicaid case pool. These workers should have more training, and resources available to them to use as they process the cases.</p>	Kit Frazer/Sumter Eligibility, Enrollment and Member Services
	<p>I think there should be some accountability on the part of our Customers. They take for granted the importance of keeping their benefits from stopping by completing the Annual Review Timely. The current system allows for ongoing abuse of the workers time. The Customers already know they can let the case close this month, come in next month and leave another application that need the same information as the last one they refused to complete and after 45 days when that case is denied, they can do it over and over again The fact is Eligibility spend 50% of our time processing applications for the same Customers who continuously apply and fail to return the requested information. If there was a 6 to 12 month penalty before you can reapply for your insurance coverage, as it is in the real world for insurance enrollment. I think the customers who abuse the system by only cooperating when they have an emergency would be</p>	Carolyn Rogers/Charleston Eligibility, Enrollment and Member Services

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	more likely to keep their coverage by complying more timely.	
	<p>Clients that receive unemployment don't have an option to receive or decline insurance. Other calculations should be looked at during this time. If a client is working on a job, they have an option to receive or decline coverage through their employer. Whereas, unemployed clients do not have this option. Other options should be made available to clients that are unemployed.</p> <p>Recommendation: I think that a 50% disregard should be given to clients that are receiving unemployment benefits that have children.</p>	Tawanka Tate/Darlington Eligibility, Enrollment and Member Services
	<p>I think that children that are Medicaid recipients and continuing their education, that they should be allowed to continue to receive Medicaid while in school. Many children coverage ends at 19. I think if they were on Medicaid at the time of graduation, and are continuing to college, that they continue to keep coverage.</p> <p>Recommendation: If they go to college, have a college category for children over 19 years old.</p>	Tawanka Tate/Darlington Eligibility, Enrollment and Member Services
	<p>It is difficult for elderly clients to obtain copies of the bank statements and life insurance policy information they need in order to be approved for the Aged, Blind, and Disabled category and the institutional categories (nursing home, home and community based services), particularly for the 5-year look-back period. Some financial institutions charge fees for sending archived statements and our clients should not have to bear the burden of paying these fees.</p> <p>Recommendation: Online tools that would enable eligibility workers to obtain life insurance information would be helpful. Also, if there were secure means of obtaining past bank statements online in compliance with the security policies of financial institutions and HIPAA regulations, that would ease the burden on clients.</p>	Cynthia Orner/York Eligibility, Enrollment and Member Services
	<p>Our policy requiring written verification that clients apply for unemployment benefits makes it difficult for some applicants who are told by the unemployment office that they will not qualify. They have to go back to the unemployment office to request a written statement proving that they have been there to apply.</p> <p>Recommendation: We accept clients' statements regarding resources and marital status (for FI-related categories); it would be helpful to accept the clients' statement that they have contacted the unemployment office and applied for benefits, as well.</p>	Cynthia Orner/York Eligibility, Enrollment and Member Services
	<p>In a digital age when so much information is available with just a few keystrokes, it makes sense to take full advantage of the technology at our disposal and glean as much information as we can online, reducing the burden of provision on our clients, particularly our disabled and elderly populations. Electronic transfer of information is also more time-efficient and, at times, more accurate.</p>	Cynthia Orner/York Eligibility, Enrollment and Member Services
	<p>There is also a great deal of regulatory burden placed on the beneficiaries. It would be helpful for DHHS to look at these also.</p>	Betsy Schindler/ Appeals and TPL Services

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	<p>Our participants must have Medicaid to enroll in the CLTC program. Medicaid eligibility slows up this process.</p> <p>Recommendation: Medicaid eligibility needs more workers to complete this task in a more timely manner. Also a worker or volunteer is needed to assist any elderly person with the long Medicaid application in their home. Some of our applicants do not have family or friend support to assist.</p>	<p>Rosalynn Radloff/Greenville Community Long Term Care</p>
<p>Policy Section 101.04.02</p>	<p>We have many forms in our program. More forms need to be added to the computer form section. For example, the incontinent forms.</p> <p>Recommendation: Enter all forms that are needed to follow policy.</p>	<p>Rosalynn Radloff/Greenville Community Long Term Care</p>
	<p>Certain policies related to Medicaid eligibility often pose a hardship to our applicants. It would seem that with all the technology we have today, we would be able to link up with other state agencies for the purposes of verifying income on behalf of our applicants. For example, our applicants currently have to pay to obtain printouts from child support to verify their income when we should be able to set up a process whereby we obtain that directly from child support.</p> <p>Recommendation: Set up computer links between Medicaid, TANF, Child Support, Unemployment, etc. To reduce the burden of income verification on the applicant and to speed up the verification for both the applicant and the employee.</p>	<p>Ellen Evans/Charleston Eligibility, Enrollment and Member Services</p>
	<p>Part of our enrollment of participants requires information to be completed by Medicaid Eligibility. The wait time for verification of Medicaid continues to be several weeks to months out prior to receiving this verification. Forms are sent to Medicaid to inquire about the status of a participant at the onset of our knowledge of the participant seeking to receive service with our program. (Medicaid Financial Eligibility Policies and Procedures). This verification process seems to be accumulating at a fast pace with staff working hard to respond in a timely manner. From the volume of work that is being requested from our area to Medicaid it appears that staff on that end is very limited.</p> <p>Recommendation: I would like to move to an electronic system that allows both parties to share some commonality with Medicaid Eligibility/ forms, verification, message board and other documents.</p>	<p>Wilhelmena Smith/Greenville Human Resources</p>
	<p>OnBase needs more fine tuning/customers don't have not having a definite worker to deal with as to the workers the workflow is too burdensome--to many steps just trying to find out if there is a referral on base.</p> <p>Recommendation: One step to immediately ID if person is on base-referral, approved/denied/pending</p>	<p>Cheryl Ogle/Charleston Eligibility, Enrollment and Member Services</p>

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	<p>From hospital provider: they need retro forms 945 for each person who is Medicaid eligible - even when not a retro request. That is burden on them to wait & us to do. From customers (recips/applicants) - specific income verifications timeframes are sometimes too strict. Other providers: some issues with Managed Care - much better than it has been - and from members about which plans to choose and how to change. Sometimes this holds up getting medications from pharmacies and care from doctors/hospitals.</p> <p>Recommendation: Elimination of the request of 945 from hospitals except when specifically asking for retro. Making some other policy about income verifications - a six week time period perhaps. Managed Care - some more phone lines for clients, special pharmacy call center for Medicaid recips.</p>	<p>Perry Foss/Colleton Eligibility, Enrollment and Member Services</p>
	<p>TEFRA applicants are asked to complete 12 original Form 921, Authorization to Disclose Information. Recently in a meeting with Voc. rehab, I was told only 1 is required; however, policy has not yet been changed. An 18 year old is considered an adult for disability purposes, however, it is still required to complete a level of care determination before TEFRA closure (did not meet disability). Even if the 18 year old meets level of care, the TEFRA must be closed and we cannot ex-parte to ABD.</p> <p>Recommendation: In both instances, correct the policy to fit the situation.</p>	<p>Tamara Douglas/Richland Eligibility, Enrollment and Member Services</p>
	<p>Too many different applications to complete for the different Medicaid categories. (MPPM 101.04.01)</p> <p>Recommendation: Universal application for Medicaid, FS, TANIF, etc.</p>	<p>Daisy Myers/ Eligibility, Enrollment and Member Services</p>
	<p>Too many different applications; why can't there be one application to cover all programs...Medicaid, Food stamps, TANIF, etc.</p>	<p>Daisy Myers/ Eligibility, Enrollment and Member Services</p>
	<p>Community partners and stakeholders are frustrated we can't tell them a specific reason(s) why a Medicaid application is pending. They state they are available to assist applicants by reminding them to submit the information or help them in obtaining and submitting the information requested so the application can be processed. A signed SCDHHS Form 1282 by the applicant allows us to share the information but the signed form must be on file or presented to us prior to information dissemination.</p> <p>Recommendation: Allow appropriate business associates inquiry only access to our MEDS data base that posts reasons an application is pending.</p>	<p>Rudolph Long/ PMO</p>
	<p>Clients constantly complain that they can't get anyone to answer calls in the counties.</p> <p>Recommendation: Someone needs to be appointed to answer the phones. Workers need to pick to times a day to check voice mails and return calls.</p>	<p>Mary Thigpen/ Eligibility, Enrollment and Member Services</p>

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	<p>Clients complain about the people at the county offices being rude and act like they are above the clients.</p> <p>Recommendation: Don't always take for granted that it is just the client complaining because it is not. If a worker is caught doing this they should be sent home for one day without pay. Second time dismissed.</p>	<p>Mary Thigpen/ Eligibility, Enrollment and Member Services</p>
	<p>*Many of the Aged, Blind, or Disabled category clients struggle with paperwork. It could be education or simply related to their age or disability. If the paperwork is not completed, their Medicaid closes, and it puts a burden on them with their doctors, medicine, and financially. Even their Social Security check is affected because Medicaid pays for Medicare. *Vehicles and life insurance (cash value) are counted as resources. These take time to verify, and 99.999% of the time, they do not affect eligibility. *People in nursing homes are required to complete annual reviews. Even though it is an expensive program, nursing home residents do not work or accumulate assets.</p> <p>Recommendation: Other than policy changes, I do not know how to ease this burden on some of the neediest in our State. Once eligibility has been determined, some of the programs could be automatic renewals.</p>	<p>Mark Tannery/Oconee Eligibility, Enrollment and Member Services</p>
	<p>1. Transfer penalty - I have had several cases where large sums of money had been withdrawn from the applicants bank account and the AR and/or family have been unable to account for how the money had been spent and the applicant due to medical/cognitive conditions is unable to state for themselves how the money has been spent. When trying to establish undue hardship to have the transfer penalty waiver, sometimes the request to waive the penalty is denied, and the applicant/families must pay private pay until the penalty expires. More often than not, the client's funds have been reduced to the point where they are unable to pay during the penalty period, and many have families unable to help with the cost. This puts a burden on the clients, families, and the nursing facilities (who are not getting paid, and may have to resort to discharging the client prematurely). 2. Requesting information for the 5 year look back - I have had cases where 3rd parties such as banks, insurance companies, and companies who issue pensions, will not release the needed information to anyone other than the actual person or a Power of Attorney (or Conservator). Many times, an application has to be denied due to failure to return information despite the efforts of the AR/client, nursing home, and case worker. Sometimes, particularly with insurance companies, even a Power of Attorney has difficulty in obtaining the needed information, and even the 30 day grace period when a case is denied in MEDS is not enough to obtain the information. 3. Income allocation - \$30 personal needs (for nursing home): I have heard quite a few clients who need more than the \$30 personal needs in order to pay for expenses such as monthly life insurance premiums. I have had at least one client who resides in a LTC facility tell me that they have had to let some of their insurance policies lapse. Many of the Medicaid clients who reside in a LTC facility do not have family members who are able to assist them paying the life insurance premiums.</p> <p>Recommendation: 1 & 2 - I am not sure particularly how these issues can be alleviated. I think that particularly with clients who are physically and financially at risk without the nursing home services they receive, there should be more leniency, particularly if Medicaid eligibility workers are able to verify that they currently meet eligibility requirements. 3. Suggestions: Either beneficiaries are allowed more than the \$30 amount, or income allocation could include life insurance premium exclusions (of course, setting a limit on how much Medicaid can allocate to life insurance</p>	<p>Pauline McCollough/York Magnolia Manor</p>

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	premiums).	
	<p>The 5-year look back for the institutional categories is difficult to achieve for families and slows down the processing of cases, hence slows down admittance to the nursing home.</p> <p>Recommendation: Go back to 3 years?</p>	Elaine Seales/Marlboro Eligibility, Enrollment and Member Services
	<p>Approximately 3 months ago Oconee went to OnBase (scanning). The backlog in OnBase is so great that application processing time has slowed greatly and now takes 30 to 45 days for a client to receive an eligibility decision. If we have to send checklists asking for more information, the process can take much longer. Why? We now spend the majority of our days working cases from another county whose back-log is so huge we seldom, if ever see an application for our county. The back-logged county has been actively using OnBase for over a year and, in my humble opinion, should not have the huge backlog they have. So now Oconee applicants suffer because we are told to work everything in OnBase on a first come, first served basis. It is not our client's fault that we have to do the work of another county, but they are certainly suffering because of it. The applicants for Oconee County are accustomed to receiving prompt, friendly service and know that we will bend over backwards to help them, if possible. If their children needed meds or surgery we would work their application immediately. If people on Medicare needed their Part B premium paid so they can afford food and heating/air conditioning, the application process would be initiated and if we had all the necessary paperwork/information, we would approve it. Whenever eligible, pregnant women were given an assumptive approval the same day as required by policy. Now, it sometimes takes days or even a week for them to get pregnancy coverage.</p> <p>Recommendation: Something needs to change. I believe each county should work applications and reviews, in OnBase, for their residents and if /when they get caught up, go out and assist other counties? Why should the residents of South Carolina suffer? I want to help the residents of Oconee County but my hands are tied now because of the new work procedures. Please help me help my elderly clients who receive \$14.00 a month in SNAP but rely on Medicaid to pay their Part B Medicare premium so they can have that \$100.00 a month to buy food. Please help me help others. Thank you.</p>	Pam Leonard/Oconee Eligibility, Enrollment and Member Services
	<p>Workbook and forms are not in Onbase. Pending letters have to be printed and mailed. Applications and verifications in Onbase have to be manually keyed into Meds system.</p> <p>Recommendation: All workbooks and forms should be in OnBase. All Mail correspondence should be automatically mailed when it is entered into Onbase system. Onbase should be able to populate at least some if the fields in Meds.</p>	Sheree Morris/Spartanburg Eligibility, Enrollment and Member Services
	<p>Self-employment budgeting is too time consuming.</p> <p>Recommendation: Count a percentage of the gross income without having to go through all the deductions that are allowed and not allowed.</p>	Sheree Morris/Spartanburg Eligibility, Enrollment and

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		Member Services
	<p>Cafeteria plan.</p> <p>Recommendation: At least have a budget sheet that would accommodate 12 check stubs instead of having to upload up to 12 budget sheets for a TMA case.</p>	Sheree Morris/Spartanburg Eligibility, Enrollment and Member Services
	<p>I get regular complaints from recipient regarding the following requests: birth certificates citizenship/identity applying for unemployment. Because I don't process applications, not sure which policy to find this information.</p> <p>Recommendation: Some workers try to get as much information as possible to prevent holding up application process while others seem to delay unnecessarily b/c they don't want to utilize the tools given to get applications processed in a timelier manner. Staff should receive the same training & tools for processing applications regardless of which office. As changes are being made, all staff should attend training or refresher courses to prevent undo information gathering from recipients.</p>	Cherlyn May/Eligibility, Enrollment and Member Services
	<p>I had another individual to call to determine if application was received because he was told by one person that it was received and by another that it wasn't, so eventually he ended up talking with me. I found out the document was scanned into OnBase, but not tracked or locked in to MEDS; hence, the problem w/accuracy.</p> <p>Recommendation: Onbase should be set-up on computers for those that are taking calls just as they're set-up for the workers that have started scanning.</p>	Cherlyn May/Eligibility, Enrollment and Member Services
	<p>Elderly recipients are confused by the Important Information About Health Care Coverage that's shared on the Notice of Actions, etc. Listing manual/policy references that support the actions seem to confuse more than provide information needed for understanding. Seniors have difficulty in finding the program or knowing what program(s) is being referenced, but can quickly find the referenced policy. Once they see that, confusion sets & the mind won't focus on why the action was sent. Maybe the policy can be written in small print @ the bottom of the notifications.</p>	Cherlyn May/Eligibility, Enrollment and Member Services
	<p>I am a hospital outstationed worker and I discussed this response with Billing management. This was the response. Policy unduly burdens the provider when Medicaid authorizations are required because they are time consuming. Also the policy unduly burdens the provider to have to require retro letters DHHS Form 945 to a resubmission for Medicaid payment.</p> <p>Recommendation: Possible alternative would be to not require authorizations nor form 945 retro letters.</p>	Lucy Keys/Kershaw Eligibility, Enrollment and Member Services
	<p>The requirement for a printout to show a client has applied for unemployment slows down processing and requires the client to make a separate trip to another Department.</p> <p>Recommendation: Self-declaration or interface between agencies would be the most expedient.</p>	Elizabeth Miller/Barnwell Eligibility, Enrollment and

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		Member Services
	<p>Most complaints from people concerning how disability is determined</p> <p>Recommendation: Because I am an admin assistant, and do not do casework, I can't offer alternatives to this issue,</p>	Wallis Grant/Richland Administrative Services
	<p>Clients want to know why it takes so long for their applications to be processed when they have done all that is required for them to do. Some have turned in applications in February and are still not pending in meds or processed yet. Some clients applied for their children because they had a doctor's appointment in the future thinking they should have their Medicaid approved by the time the appointment came.</p> <p>Recommendation: Hire more people to get the job done if only temporarily or move some people around to help out until the back log is completed</p>	Gloria Harris/Kershaw Medical Services
	<p>Transitional Medicaid-Persons eligible for transitional Medicaid should receive it for a limited time, no quarterly reports. At the end of the limited period they should reapply. Current regulations award eligibility up to two years, divided into three periods with quarterly reports due. At the end of this period, customers are contacted and eligibility into another category can continue without a new application.</p> <p>Recommendation: When income exceeds a certain limit, you are no longer eligible. If a transitional period is to be given, give a time limit with no reports due.</p>	Mary Bryson/York Eligibility, Enrollment and Member Services
	<p>Cafeteria Plan budgeting. Why not just use the adjusted income noted on the check stubs? Current regulations insist that we enter figures on the budget sheet and copy each calculation to show the adjusted income, for each pay period.</p> <p>Recommendation: Use the adjusted income amount indicated on the pay stubs.</p>	Mary Bryson/York Eligibility, Enrollment and Member Services
	<p>Transitional Medicaid Assistance (TMA) a. gathering needed wage information to determine the point of income ineligibility can be difficult and sometimes impossible b applying appropriate disregards based on the TMA Period confuses staff</p> <p>Recommendation: a. Assess a penalty for untimely reporting to either (a) deny TMA, or (b) continue Medicaid for just a couple of months b. Give one disregard and a set period of continuous eligibility</p>	Shearl Jones/Colleton Eligibility, Enrollment and Member Services
	<p>The process for completing the 60 month look-back for transfer of resources a. Tracking the spend-down of liquid resources (and the imposition of a penalty for transfers for less than fair market value) requires a lot of information gathering and is burdensome for the applicant as well as staff conducting probate court searches, which is a time-consuming process that most often yields no additional information that is useful in completing the eligibility</p>	Shearl Jones/Colleton Eligibility, Enrollment and

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	<p>determination.</p> <p>Recommendation: a. Develop a policy to allow a tolerance for transfers less than the countable resource limit. b. Develop a policy that provides specific instructions for determining when/how to limit the search based on the date of death or allegations regarding inheritances</p>	Member Services
	<p>Having to wait an extended time for a disability determination is a burden. It usually takes 90+ days for a decision. This is the complaint I receive most often from applicants.</p>	Faye Usry/LEP
	<p>In order to qualify for services from a need-based Department, one must apply or have their circumstances reviewed via an exparte related process. Most agencies require an application. We are currently looking into combining the application and other eligibility functions with DSS. This would be very beneficial to the customers, because (1) we mostly service the same groups, (2) it has the potential to decrease the wait time for customers because they are often seen in the same office, but directed to different windows and workers requesting identical information and (3) it would improve customer service. I have personally spoken with customers who were frustrated with the process of entering a lobby, only to be directed to different windows for related services, again requesting the same info. I do hope that one day we would take this process further by implementing a statewide joint application that could be used by all state agencies providing services. Perhaps, even IISS (Inclusive Intake Statewide Stations) where customers could go and apply for any service. Applications would then be forwarded to the appropriate Department.</p> <p>Recommendation: If the decisions are reached to consolidate some processes at DSS and DHHS county operations, it should begin with the application process in the lobbies. Office lobbies that are co-located should be transformed into one. The process should also be seamless to the customer. This transformation should be new, with triage stations and just a new way of doing things. If we want to continue to process separately behind the curtain that's fine; however, the perception to the customer and public should be one, new, positive, efficient and outcome driven to achieve optimum customer service, satisfaction and to provide the best healthcare for the least amount to the taxpayers.</p>	Patricia McWhite/ Eligibility, Enrollment and Member Services
	<p>Intake of new participants -some providers and individuals feel the process is too lengthy. Rule- statewide waiting list that seems to take longer to process and information from intake not submitted or transferred to area offices incorrectly or not completed.</p> <p>Recommendation: Don't have any ideas. The old way of intake process had its own issues as well.</p>	Marcell Wright/Charleston CLTC
	<p>205.05.02 Earned Income Disregards Fifty percent of earned income is disregarded for the first four months after employment begins and a standard disregard of \$100.00 for each month thereafter that earned income is received. When the 50% disregard has been allowed for four consecutive months, the individual may not receive it again until he/she is ineligible for Medicaid for 12 consecutive months. If a member has had family planning during that 12 month period, the 50% earned income disregard cannot be used again.</p> <p>Recommendation: Exempt the family planning category from this policy.</p>	Susan Bailey/Charleston Eligibility, Enrollment and Member Services

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	<p>Many clients have limited literacy skills and are intimidated by the consolidation application. Though it serves the needs of the Department, it does not recognize the needs of our clients. Often, clients call workers for help in completing the application. The instructions on the application, i.e., "please answer 18 and 19 only if you are..." confuse clients.</p> <p>Recommendation: Clients might respond more favorably to a simplified version of the application, similar to reviews, or an application specific to programs.</p>	Susan Bailey/Charleston Eligibility, Enrollment and Member Services
	<p>Being a new employee to DHHS but having prior knowledge with Medicaid issues it appears there could be some way to assist consumers without terminating the Medicaid due to failures to return information. Maybe give them an extension to allow time to complete the process and with repeated delays send final notification before final termination. Sometimes you have elderly folk that cannot access the information and depend on family that are also busy and this causes a delay. Not being able to reach a Medicaid worker is a major problem to get basic information/ask questions. Maybe using a universal calling center that assist with "fielding" questions/answers. Not being able to reach a Medicaid worker also causes a problem for case workers/social workers/adm. staff in obtaining information in dealing with day to day case management for participants. Having a "back door" number for agencies to make contact with a worker would be helpful. It feels as if the Medicaid eligibility offices and CLTC are not a part of the same Department when it comes to being able to call and discuss case issues. It's just difficult to get through to ask even a basic question. Have noticed a need for more training for Case Management providers. Feel the case managers should have some degree of "case management experience".</p>	Carolyn Smith/Georgetown CLTC
	<p>Clients who are currently ssi eligible that have a transfer are not penalized under institutional guidelines; however a non-ssi recipient is penalized if they have a sanctionable transfer with in the look back period.</p>	Christy Peavy/Horry Eligibility, Enrollment and Member Services
	<p>Having customers get child support payment printouts from court houses, these are not free and sometimes they have no funds to get these printouts or even to go get them</p> <p>Recommendation: Instead of court printouts- let the check stubs or order be sufficient</p>	Muriel Brown/Charleston Eligibility, Enrollment and Member Services
	<p>Having those individuals who state they are disabled or attempting to be determined disabled, apply for unemployment benefits, when unemployed States one must be ready, willing and "able" to work</p> <p>Recommendation: The above is self-explanatory</p>	Muriel Brown/Charleston Eligibility, Enrollment and Member Services

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>Children turning 19 and in school, no longer eligible for coverage other than family planning or pregnant</p> <p>Recommendation: Allow those children who are still in school,(high or college) up to at least 21 be able to receive full coverage if other categorically requirements(i.e. income) and proof of enrollment in school are met</p>	<p>Muriel Brown/Charleston Eligibility, Enrollment and Member Services</p>
	<p>The more burdens causes hardships for our clients and for the workers</p>	<p>Muriel Brown/Charleston Eligibility, Enrollment and Member Services</p>
	<p>Policies for FI related programs are more relaxed than for elderly/disabled. This includes income limits. Unemployed adults may meet requirements and someone who has worked and now unable to has a low income limit.</p>	<p>Susan Harnet/Greenville Eligibility, Enrollment and Member Services</p>
	<p>The participant choice for suppliers of incontinence products and other providers is extremely long. Most complaints I've heard from participants state that they really don't care who supplies them and it's difficult for some people to make a decision, but they are forced to decide. They'd be happy to take the next one in rotation if that was a choice they were allowed to make, as long as they could change it, if they were not satisfied.</p> <p>Recommendation: Have a choice of next random supplier or product or service. Have the random choice rotate.</p>	<p>Teresa Burbol/Greenwood CLTC</p>
	<p>This is not a policy problem but a state office procedural problem. Problems started to occur when the scanning system ONBASE came into effect as different counties went live. There is a back log of work and clients are very upset it is taking so long to get help. We all are accepting calls with disgruntled applicants which take time away for working on the backlog of work that needs to be done.</p> <p>Recommendation: Hire more SSI Institutional Eligibility workers who are properly trained or retain those who are not following correct policy. SSI Institutional workers have left or retired and more workers were not hired to replace the ones we lost.</p>	<p>Judith Tidwell/Oconee Eligibility, Enrollment and Member Services</p>

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>SSI recipients are being required to enroll in a health plan instead of being given a choice to enroll in a plan or stay fee for service. Some of these recipients who are SSI need placement in a long term care facility. These long term care facilities are not accepting the patients into the facility until they are fee for service but when recipients call requesting they be switched to fee for service because they are entering a skilled nursing home, they are being told that they can't because they are required to be in a managed care plan. When State Office was notified of this problem, we were told that once entry into the nursing home, the health plans are required to pay up to 90 days before recipients are placed in fee for service. The problem is that the nursing homes will not admit anyone enrolled in a plan, so these patients don't get placed into these nursing homes. They end up staying in the hospital longer than they need to because they can't be discharged home or placed into a long term care facility.</p> <p>Recommendation: We need to go back to allowing SSI recipients to have the option for staying fee for service or at the very least, have the entry into a long term care facility be an automatic reason to disenroll from health plan within 30days.</p>	Helina Selassie/Charleston Eligibility, Enrollment and Member Services
	<p>Citizens that do not meet "Aged/Blind/Disabled Pcat. The individuals that are between 40 - 65 with no minor children in Household and not yet hit the "65" age. These individuals have no PCAT that they are eligible besides limited FP coverage. This age group of citizens is developing medical issues / conditions that are in need of treatment but CAN NOT afford the treatment with no Medicaid Eligible coverage to apply for....</p> <p>Recommendation: The LIF Pcat allows YOUNG adults with children coverage to qualify for this pcat if they meet income/resource limits. Why not enforce limitation as if no EARNED income for these young adults limit amount of coverage as in. Example: Boy Doe applies for LIF with his 10 year old son.. He states he has no Earned or unearned income (food stamps) doesn't qualify for UCB referral, etc. Give him coverage under LIF if meets eligibility rules HOWEVER LIMIT THE TIME frame without proof of earned income for at least 6 months - year. Then use that revenue saved to create a PCAT for the older citizens giving the same medical coverage opportunity..???</p>	Wendy Hiers/Colleton Eligibility, Enrollment and Member Services
Estate Recovery		
	<p>The Estate Recovery for participant applying for and receiving CLTC Waiver Services with low income, and limited resources, property, etc. There is a fear of losing property inherited after the person dies. Property that families have worked so hard to obtained, and maintain for many years.</p>	Yvonne Chess/Aiken CLTC
	<p>Estate recovery on elderly applicants. Many of their children do not know all details pertaining to their grandparents who are deceased and parent(s) not capable of providing information.</p> <p>Recommendation: If applicant is unable to furnish information have instructions for family on possible ways to obtain.</p>	Susan Harnet/Greenville Eligibility, Enrollment and Member Services
General		

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	Some of our regulations are not strict enough for someone who is getting free medical insurance; we really need to be more diligent in detecting fraud in our programs. It should be required that the parents make an effort to get employment rather than just feed off the taxpayers of SC. There are some real needs in our programs and then there are those who are just using the taxpayers to pay for something they can and should be responsible for paying. It would be nice if the state could find a way to subsidize health insurance premiums for families that work instead of paying for all the health care costs and making it impossible for families to get their own insurance coverage. Many people would like to work and have their own health insurance but the cost prevents them from doing so. If the state could subsidize the cost instead of paying the entire health care bill for the family it would give them options to have their own insurance instead of depending on the state health care program paying the entire costs. We would then become what the program was started to be, a help up instead of a hand out!!	Sherry Anderson/Horry Eligibility, Enrollment and Member Services
	The Department appears to be moving away from cost reports, particularly state agencies and certain other provider types, thus removing time intensive and financially expensive tasks for those provider groups. Providers are appreciative of that effort.	Debbie Strait/Columbia Controller
	Our government is all over the place and we as tax payers and citizens whether we pay little or lot the money that is needed will not be allocated for the state so without taken the money or assessing the true problems in our state government problems will arise more and more and come back. See we are expected to the work but not get paid for doing the work. They have burden us with the rules and regulations but they do not abide by the law as well. Recommendation: Need to have workers in place that abide by the rules and have hire management backing us on the decisions. I have learned we can do our job right all day but someone will always be unhappy with it.	Anissa Cruse/ Sumter Pediatrics
	Thank you for the opportunity to participant in the survey. The development of the DHHS Burden Busters team sounds as though it may provide a wonderful opportunity to identify areas of regulatory concerns/burdens and possibly lead to improvements in service delivery.	Tracey Jackson/Greenwood Community Long Term Care
	Perhaps we should have a permanent standing committee to review regulations.	John Wilson/Richland Eligibility, Enrollment and Member Services
	Moving - Furniture is always being moved when staff is moved. Set up each and every office only once with a desk, filing cabinet, etc., and leave the furniture in it. If someone moves, the furniture stays in their old office and they use what is already set up in the new office. Money saved - Labor, wear and tear on moving furniture and filing cabinets.	Karen Maine/ Ancillary Reimbursement
	Baby Friendly Hospitals and many other programs are "feel-good" policies that do nothing to help stop the rampant abuse and waste presently seen in South Carolina. While some policies such as scheduling labor at the mother's convenience will save taxpayer dollars and lead to better infant outcomes, much more aggressive action needs to take place to stop excessive use and abuse by recipients and providers alike.	Holly Furne/ Compliance and Performance Review
	There are a lot of people in our society that are doing without medical attention that they need, I know the new rules	Carmen

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	will hopefully will make Medicaid eligibility more accessible to the public, however in my opinion no one should suffer with pain and illness because they cannot afford a doctor or medicine.	Roa/Aiken Eligibility, Enrollment and Member Services
	State employees are overworked and underpaid.	Mary Thigpen/ Eligibility, Enrollment and Member Services
	We should have only 1 password for all interfaces. You have combined some of them but we still have 3 or 4 passwords.	Mary Jeffers/Horry Eligibility, Enrollment and Member Services
	Internally - there are too many papers/forms etc. for staff to travel and go to training.	Lynn Martin/ Project Management Office
	From my perspective at lot of the regulatory burden on South Carolina businesses, aka providers, is the result of Federal regulations that we as a State cannot change. While the goals of these regulations are to ensure oversight of the Medicaid program and that that taxpayer dollars are spent appropriately, this Department can certainly play a role in making sure businesses understand regulatory expectations. Even necessary regulation becomes an undue burden when it is not clearly and fairly communicated to those impacted by it.	Kathleen Snider/ Compliance and Performance Review
	Follow the policies set by the state, chain of command. Recommendation: Set plans to ensure the process is binding and that management understands the point of the supervisor when proof is given by them that they follow through with termination of an individual during the probation periods.	Kathy Tucker/Dorchester Eligibility, Enrollment and Member Services
	New computers are need in CLTC offices. The one I am using is over 10 years old. Recommendation: I was informed that there are new computers. So, where are they? Apparently more computer personnel are needed.	Rosalynn Radloff/Greenville Community Long Term Care
	I am in the process of hiring two RNs. The new RNs will have a starting salary that is higher than the loyal employees that have been here for over 10 years. I do not like this policy. The other RNs should have a salary increase. Recommendation: Raise the nurses salaries to meet new employees	Rosalynn Radloff/Greenville Community Long Term Care

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>Our State Social Workers have not had a salary increase</p> <p>Recommendation: Give the Social Worker's a raise</p>	<p>Rosalynn Radloff/Greenville Community Long Term Care</p>
	<p>Starting salaries for new RN employees is low compared to area hospitals. I am told that the take a \$30,000 decrease in salary to be hired in CLTC.</p> <p>Recommendation: All nurses and new hires need a salary increase.</p>	<p>Rosalynn Radloff/Greenville Community Long Term Care</p>
	<p>Not necessarily a regulatory burden, but just concerned that we will be adding many more members on Medicaid with fewer staff, a new system to get used to and maybe with policy changes. Would like some more updates from upper management on the re-structuring. Staff wants to know about incentives. Staff is concerned about job security & learning new policies in short amounts of time.</p>	<p>Perry Foss/Colleton Eligibility, Enrollment and Member Services</p>
	<p>Policy needs to be written before implementing a program. I am processing expedited Foster Care cases and have very little guidelines for the program. A meeting is planned so I hope to give/receive input soon.</p>	<p>Tamara Douglas/Richland Eligibility, Enrollment and Member Services</p>
	<p>There are many rules and regulations with anything related to the government whether State or Federal. Each new law or regulation that is passed adds one more thing local offices must deal with. From motor voter registration laws to citizenship/noncitizenship laws, each new act adds one more requirement on the eligibility worker. Eventually, these "one more" add up to many and casework suffers. The clients of South Carolina do not receive the attention they deserve. Customer service needs to remember when looking at regulatory changes and what is important. Remember our clients and their situations. Some would easily fall through the cracks if it were not for caseworkers who go that extra mile and try to help.</p>	<p>Mark Tannery/Oconee Eligibility, Enrollment and Member Services</p>
	<p>Use evidence based research / findings, conduct town hall meetings in the areas (.i.e. rural) where a lack of transportation prevents people from attending meetings in the urban area , conduct phone survey of the people effected by the proposed laws, regulations, etc.</p>	<p>Yvonne Chess/Aiken CLTC</p>
	<p>I hear various complaints, but am unsure of how to classify them.</p>	<p>Wallis Grant/Richland Administrative Services</p>
	<p>None. They are pretty clear and I don't think are overly burdensome or hard for clients to understand. They just don't want to do all the things they need to.</p>	<p>Carroll Little/Greenville Eligibility, Enrollment and</p>

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		Member Services
	<p>When it comes to state employees and the choices we have for health coverage-it seems unfair to only have blue cross blue shield as the "only" provider for our health insurance-whether it be blue choice, state plan or the savings plan, all are administered by blue cross, and if there are choices they should be affordable to employees. Not like when there was CIGNA and cost for most was~ \$500. Considering our wages are so far behind, who could have possibly afforded it(before CIGNA left, was informed by HR who came to help with open enrollment, that in this DHHS Department, in the entire state- only 4 people had CIGNA. So now all we have is blue cross who is on the regulatory board.</p> <p>Recommendation: Provide more choices for all state employees, with competitive prices and in line to the poor wages we receive and can't seem to ever get any kind of decent raise without issues(like giving a 2% raise and then want to go up 1 1/2 on the cost of the insurance.</p>	Muriel Brown/Charleston Eligibility, Enrollment and Member Services
	I have never had any complaints about rules/regulations for applying for Medicaid.	Janet Michaels/Horry Eligibility, Enrollment and Member Services
	<p>Lack of workers</p> <p>Recommendation: Hire more workers and simplify policy</p>	Peggy Harbin/Anderson Eligibility, Enrollment and Member Services
	Rude client who do not understand our rules and regulations	Erica Cleveland/Oconee Eligibility, Enrollment and Member Services
Managed Care		
	some members just want regular Medicaid instead of having to choose a managed care plan	Carroll Little/Greenville Pediatric Rapid Access Center/Eligibility, Enrollment and Member Services

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>Currently, Medicaid Recipients in Managed Care Areas are seeing any provider they wish to, contrary to the policy behind Medical Homes and Coordination of Care. Further, these Medicaid recipients do not have photo identification and are often not tasked with providing any identification when they receive services. This adds to fraud and abuse but we don't know the extent of this problem as Program Integrity has no oversight of Managed Care because the contract language was not drafted to address the MCOs regulatory and procedural oversight and fraud/abuse prevention.</p> <p>Recommendation: Have SCDHHS attorneys draft tight contract language giving Program Integrity, with their infrastructure and expertise the ability to oversee and implement corrective actions where MCOs are deficient and/or ineffectual in managing Medicaid funds paid them.</p>	Holly Furne/Compliance and Performance Review
	<p>HMO Medicaid has not been explained nor is there a source for clear explanation for participants, nurses and nursing homes. The agreement made in good faith by those in Columbia with the HMO's is not what is in practice in reality. As a result, participants are assessed and suddenly in the process they are in an HMO. If referred to the HMO, those employees have no idea what Community Choices is and participants are told there is no "regular Medicaid". Participants have to disenroll from HMO and it is impossible to have them informed about the advantages or disadvantages if the nurses do not have an adequate referral source. Also, there are no nursing homes who will take a participant with HMO Medicaid. I have been told that there has been payment for only 6 days of rehab, paperwork is overwhelming and payment for stay takes 6 months to a year to reach the nursing home. This means a backlog for the hospital which results in an expensive Medicaid bed, a participant inappropriately remaining in hospital or a discharge that is not ideal.</p> <p>Recommendation: Have a meeting with the HMO representative's present and a representative from each CLTC office present, possibly on a small, local scale and have contact person at the HMO plus paperwork that has hard facts we can count on. Thank you.</p>	Laura Vallone/Horry Long Term Care and Behavioral Health Services
	<p>When Healthy Connections Choices came into existence it created problems for our clients. Choosing a health plan was something some of them neither understood or cared about. People were placed in HMOs without understanding the process. Pharmacies and Doctor Offices were telling clients they no longer had Medicaid which freaked them out....but ultimately they were in a HMO that Dr. did not accept. I believe this has created significant problems for our healthcare providers also.</p> <p>Recommendation: More education and user friendly services for our clients.</p>	Toni Shoaf/Greenville Eligibility, Enrollment and Member Services
Other State Agency		
	<p>Food Stamps put children on without the name of the child's parent attached to them. They pull every child out and put them in a separate House Hold (HH). Once the parent is eligible to be on Medicaid, every child has to be closed and put in the HH of the parent. Also, in order for the parent to call the 1-887-556-4642 number to discuss what plan their child should go on and to select a plan they are told they can't discuss it with them because the parent's name does not show up in the HH for the child.</p>	Barbara Alexander/Lexington Eligibility, Enrollment and Member Services/
Policy		

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	<p>Our Medicaid policies are often poorly written by non-attorneys and often not even health care providers so that egregious abuse occurs and we have no leg to stand on to recoup the miss-spent funds. For example, providers were paid \$167.70 to perform an 80101 CPT code drug test that often amounted to an inexpensive qualitative drug test costing less than \$10.00-20.00, using their own office staff to perform such a test. Other expensive procedures, such as Supartz joint injections can apparently be performed by any physician, without prior authorization. This same cardiologist who performed 6-8 cardiac tests on each patient is now performing these joint injections, as his ability to order diagnostic tests in his office is limited. All these policies are in the Physicians Provider Manual, Section 2, see High-Cost Radiology Procedures requiring Pre-authorization, and Alcohol and Drug Testing Policies. As to Managed Care Organizations, we see the same abuse of high-cost radiologic testing and drug testing, with no apparent surveillance of the abuses that Program Integrity sees. MCOs are to be tasked with surveillance of fraud and abuse, are not noting and addressing these problems, and Program Integrity has NO statutory authority to monitor MCO misuse of services, nor ability to recoup overpayments. Further, the MCOs appear to have many internal problems requiring them to complete Action Plans to correct their deficiencies and we want all Medicaid patients to enroll in these MCOS?</p> <p>Recommendation: Have health care providers, if not attorneys, to draft policies congruent with CMS regulations for Medicare, which seem to be workable. Begin placing limits on certain benefits that are prone to abuse, such as outpatient visits for adults and children, and ED visits. Where CMS regulations for Medicare are not workable for pediatric and obstetric patients, have attorneys and health care providers jointly draft appropriate, clear, cost-effective language to minimize ambiguities and "silent" areas in policy.</p>	Holly Furne/Compliance and Performance Review
	<p>There should be a universal web search for policy and procedures.</p> <p>Recommendation: There should be a concordance or a web search where I can type a statement or a word or a question, and it will direct me to a place in the Policy and Procedure Manuel to assist me. The Policy and Procedure Manuel helps in itself of course but it should be much easier. Especially when you have a question and it takes a few min. to locate the correct place in the manual. But if you have a place to type a question and it pops up telling you where you can find the answer that will help out even more.</p>	Angela Chandler/Darlingt on Eligibility, Enrollment and Member Services
	<p>I think the Policy and Procedure Manual for CLTC could be rewritten to be more specific and less wordy. It is a regulatory burden in itself in many ways.</p>	Elizabeth Livingston/Richland Community Long Term Care

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>SCDHHS policy should not cause CNAs to lose their jobs, leaving health care employers to recruit, orient and train new employees if the CNA employee fails to renew their certification. SC policy should not cause CNAs continuing their education in nursing school to lose their nurse aide certification because they aren't working for money while attending college but they are using their skills in the nursing classes and labs.</p> <p>Recommendation: Change SC nurse aide certification policy to minimize burden of costs to healthcare employers, college students, graduates of SC public high schools or graduates of state sponsored Family Independence or Workforce readiness classes/programs. A CNA who is working as a CNA or in Nursing School at the time of the expiration of his/her certification should not have to retrain or retest. Upon producing proof of employment or enrollment in nursing school, the requirement for retraining and retesting should be waived. However, the recertification fee or some such monetary penalty should be charged to the CNA for loss of certification. This is the policy of other states. Reason for policy update: The current SC Nurse Aide Program follows federal regulation when it requires CNAs to renew their certifications every two years. If a CNA fails to renew his/her certification, he/she loses the ability to work in a Medicaid certified nursing home by federal regulation or in any other health care setting where not Federal regulations nor SC law, but the SC employer's policies require current nurse aide certification such as in the industries of home health, hospitals, assisted living, etc. Upon loss of certification, the nurse aide must retest and possibly re-train via a state approved nurse aide training program (NATP) if the first NATP was not a state approved NATP at the time of his/her training. SC did not require test candidates to have completed state approved NATPs to be eligible to take the certification exam during the period 1989 – 2001. In some cases CNAs trained via SC tax payer money in the form of public schools, SCDHHS sponsorship, Unemployment Workforce initiatives, or Family Assistance who do not renew their certification may need to be retested and retrained again using SC tax payer money. Example: Rep. Jerry Govan's former nurse aide training program (NATP) in Orangeburg was not a state approved NATP until such time as it was required in order for graduates to test. A majority of high schools in the state did not have their NATPs state approved until it was required in order for graduates of the programs to take the nurse aide certification test. Each time one of these graduates who trained prior to the state approval of their NATP lets their certification expire, they lose their jobs and must retrain and retest possibly using SC tax payer money again.</p>	Cindy Pedersen/ Community Options
	<p>It would be helpful to have more information in the policy manual regarding information that is needed to process applications (what is absolutely required? what is the minimum required?). Answers to some of these types of questions cannot always be found in the policy manual. The policy manual addresses how to process applications, but does not always have thorough explanations. The examples can be very generic and not reflective of real-life situations.</p>	Alison Mantini/Charleston Eligibility, Enrollment and Member Services

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>Medicaid programs have different policies. There are many programs making policy hard to learn and keep up with changes. Counties interpret policy differently so there is a lack of consistency across the state. If policy was changed to make it simple and clear workers could read the policy, understand it and apply it the same in each county. In most counties the vacancies have not been filled, so the workers are covering their jobs and the work left behind from the vacant position. Eligibility workers are covering the front desk and doing their jobs as well. Some counties have not had supervisors for months. Managed Care has been difficult for many of our clients as well; They cannot see all of the doctors that they want to see as well as having transportation issues. When we approve a pregnant woman for Medicaid it is at least one month before she gets into a Managed Care Plan and sometimes as much as three. Many doctors will not see them until they are enrolled in a plan. The Medicaid eligibility worker approves the case on the same day or at least by the following day as policy is clear on but they still can't get medical care until they get their Managed Care card.</p> <p>Recommendation: Policy needs to be streamlined and consolidated in the different Medicaid programs. The policy manual should be clear and easy to understand, so workers use the same standards. The vacancies need to be filled. In some counties the staff is reduced by a third with the same amount of cases. Quality needs to improve but until the workforce can handle the work that is not going to happen. Even the work of the staff with the highest standards is suffering. Managed Care should care for the patient as soon as they are approved for Medicaid. The enrollment period is causing our citizens not to get medical care that they need timely.</p>	Kathy Frazer/Chester Eligibility, Enrollment and Member Services
Procurement		
	<p>There are several policies - as expressed in provider contracts - that require providers to supply information that seems more related to controlling their organization than monitoring the provision of services, such as requiring the provider to provide organizational charts and bylaws, setting minimum hours of operation and minimum size and location of office space.</p> <p>Recommendation: I am not sure that we ever seek the information that we are "requiring" or that anyone ever actually reviews it. This language should be removed from the contracts and replaced with language that actually influences the quality of the services provided.</p>	Vicki Johnson/General Counsel
	I receive many complaints related to the regulatory burden of the SC Procurement Code. These complaints are from most often internal sources rather than external sources.	Vicki Johnson/General Counsel
Provider Enrollment		
	<p>Comments from providers on the enrollment and prior authorization of MH providers and services. In addition, each Managed Care company must also individually credential and approved LIPs and/or therapist. Also different referral and authorization forms.</p> <p>Recommendation: One mandatory referral form; common referral processes; common credentialing criteria no matter the MCO or payment source</p>	Lynn Martin/Project Management Office

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Provider Integrity		
	<p>Section 1877 of the Social Security Act, 42 U.S.C. Section 1395 et seq. also known as the Stark Law, prohibits physicians and other health care providers from self-referring to other owned entities providing Designated Health Services, hereafter, DHN, as providing an improper conflict of interest where provider benefits financially from self-referral. The “ancillary services exception” to Stark III vitiates Stark by allowing providers, commonly physician groups, to purchase expensive imaging and other diagnostic equipment and refer patients to have these tests, claiming medical necessity. One internal medicine group’s cardiologist and his wife purchased a CT scanner, echocardiogram machine, nuclear stress testing, and other equipment and routinely ordered millions of dollars of testing on a large number of adult patients, often with no symptomatology, and a 95% normal rate, but we recouped 38K. Second, our MMIS system is so antiquated, it is incapable of “editing” excessive use so that Medicaid patients can exceed their twelve visits easily, with those extra visits being paid. Other edits are not recognized, allowing other billings to be improperly paid. Further, we are unable to program the system with any enhancements that would “catch” billing errors before the money is paid. I have personally seen numerous patients receive 20-30 visits in one calendar year PLUS numerous ER visits when less expensive care was available.</p> <p>Recommendation: CMS and/or the Legislature should close the Ancillary Services Exception to high cost testing such as CT scanning, Nuclear stress and other testing, Echocardiography/other ultrasonography, high-cost Gas Chromatography and Mass Spectroscopy and other high-cost diagnostic testing and the pre-certification process should be rigorous, rather than a pro forma entry of CPT code, ICD-9 code, and brief patient history resulting in automatic authorization. MMIS needs to be overhauled substantially to place necessary edits and other forms of “logic” into place to prevent payments from being made contrary to established policy. This would require substantial capital expenditure as the system is too antiquated to handle the increased burden the increased Medicaid population imposes on South Carolina tax-payers.</p>	Holly Furne/ Compliance and Performance Review
Provider Service Center		
	<p>(Call Center - Program staff not giving out phone numbers) Provider's calls are sent to our area from the call center with calls that have absolutely nothing to do with our area because we happen to answer our phones. We try to find out where to send the call, but since we have no phone listing and most program areas are not allowed to give out their phone numbers, providers are being passed around the Department. In some instances when we call an area, we at the Department are even sent back to the call center. The call center has been stated as being rude and not very informative on Medicaid subjects that they are being asked about.</p> <p>Recommendation: A list of the contact person for each program area. Do not really need to know where they are located, but at least who it is and a contact's phone number. As for customer service, a policy of not giving out a phone number is BAD customer service. If the call center was given a list of different types of provider numbers, example: RHC002 (Rural Health Clinics), NH2222 (Nursing Homes), they could at least know which area to send the call to in some instances. Again with an actual contact person, not an automated system.</p>	Karen Maine/ Ancillary Reimbursement

Statute/Rule/Regulation/Policy	Burden and Recommendation as described by Submitter	Submitter's Contact Information
	<p>Providers call the United Way Call Center trying to get help in resolving claims; they are informed that they are to call Provider Service Center. Their response is I call but did not get the help needed. When the provider cannot get paid they are billing the beneficiary.</p> <p>Recommendation: That the Provider Service Center is staffed with knowledgeable staff members and staff that is willing to provide the assistance that the providers need.</p>	Martha Chandler/ Eligibility, Enrollment and Member Services
Third Party Liability		
	<p>First, the requirement to verify life insurance is a burden to applicants. Most clients I deal with don't have excessive amounts of insurance. If discovered, they just go and draw up a burial contract to eliminate the problems. This would save workers lots of time. We now have to wait on insurance companies to verify the policy values. This could delay processing time for several weeks.</p> <p>Recommendation: For life insurance, we should accept declaration statement from client as verification and not wait to hear back from policy verification.</p>	Lisa Adams/Darlington Eligibility, Enrollment and Member Services
	<p>Most of the recipients participating in the MCO programs do not even know they are in a program, they only understand they have Medicaid. We need to better educate the beneficiaries in order for them to reap the most health benefits. Recipients must keep us updated with changes in primary private insurance plans but must also inform their MCO. Perhaps it would be possible to have more open and frequent communication with the MCO's pertaining to the changes in the TPL Recipient Summary Page of the MMIS. Knowing we are making a shift from MHN's to more MCO participation, the time may be at hand to explore the possibilities of better synchronized work efforts between SCDHHS and our MCO's. In fact this should be a goal for all of our partners in healthcare efforts, Magellan, DentaQuest etc. At this point in time I believe we only communicate changes made to TPL in MMIS once per month.</p>	Heather Meetze/ Appeals and TPL Services

7.0 APPENDIX C: INTERNAL SURVEY INSTRUMENT

Team SCDHHS-

We were invited to participate in the Regulatory Burden Task Force process (Executive Order 2013-02). The mission of the task force is to identify burdens to stakeholders that are caused by statutes, rules, regulations and policy that outweigh the intended benefits. This is the perfect place for you to be the voice of the stakeholder and let us know what regulatory burdens you have observed and/or complaints you hear in the field. A group of us at SCDHHS (aka Burden Busters) are preparing a report due May 15, 2013, and we *need your help*. We would like to get your feedback by **April 12, 2013**, using the survey in this email. Please select the link below to complete the Regulatory Burden Survey.

<http://www.surveymonkey.com/s/HHSRegulatoryBurdenSurvey>

Your input will be combined with other feedback and used to develop a comprehensive package of “burdensome” issues. Any issues identified will be prioritized and the committee will recommend appropriate action items. Our process includes the development of a website containing a “virtual” policy book, links to statutes and regulations and other items designed to help us improve our delivery of Medicaid services for South Carolina.

Thank you in advance for your completion of this survey.

1. Please enter your contact information
 - First Name
 - Last Name
 - Telephone Number

2. Please enter your Location from the drop down menu.
3. Please enter your Program Area from the drop down menu.
4. Have you personally observed an undue regulatory burden or received feedback from customers, providers or other stakeholders who conduct business with HHS regarding statutes, rules, regulations or policies that unduly burden their operations.
 - a. Yes
 - b. No
5. Describe specifically how the statute, rule, regulation or policy unduly burdens operations. Be sure to identify the relevant statute, rule, regulation or policy in your response.
6. If possible, provide alternative approaches that you believe would reduce the burden of the provision.
7. Do you have another issue related to regulatory burden to share?
 - a. Yes
 - b. No
8. What other feedback do you have regarding regulatory burden?